CALAIM INCENTIVE PAYMENT PROGRAM (IPP)

Payment 2 Progress Report (*Updated Spring 2023*)
Submissions 2-A and 2-B

Contents

Cover Sheet

Response Required to this Section

This document outlines instructions for completing the Payment 2 Progress Report submissions.

When submitting Payment 2 responses, managed care plans (MCPs) should include: (1) the MCP name; and (2) the county to which this Gap Assessment Progress Report applies in the header of their submission (header should repeat across all pages except Page 1). MCPs should also include a Cover Sheet with tables as shown below.

MCPs that operate in multiple counties will need to submit a separate Progress Report for each county in which they operate.

1. Details of Progress Report	
MCP Name	Anthem
MCP County	San Francisco
Is County a Former Whole Person Care (WPC) Pilots or Health Homes Program (HHP) County?	Yes
Program Year (PY) / Calendar Year (CY)	Program Year 1 / Calendar Year 2022 Payment 2 (Submission 2-A and Submission 2-B)
Reporting Periods	Submission 2-A: January 1, 2022 – June 30, 2022 Submission 2-B: July 1, 2022 – December 31, 2022

2. Primary Point of Contact for This Gap Assessment Progress Report	
First and Last Name	
Title/Position	
Phone	
Email	

End of Section

Introduction

The CalAIM Incentive Payment Program (IPP) is intended to support the implementation and expansion of Enhanced Care Management (ECM) and Community Supports by incentivizing 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; and encourage take-up of Community Supports.

IPP Payment 1

To qualify for Payment 1 of the IPP, MCPs submitted the Needs Assessment and the Gap-Filling Plan in January 2022. The Needs Assessment was intended to provide a "point in time" understanding of ECM and Community Supports infrastructure and provider capacity prior to launch. The Gap-Filling Plan—which MCPs were to develop in conjunction with local partners—outlines MCPs' approaches to addressing gaps identified in the Needs Assessment.

DHCS issued Payment 1 to MCPs in April 2022 on an interim basis, based on DHCS' review and acceptance of Submission 1. MCPs must demonstrate progress on activities outlined in their Gap-Filling Plan to fully earn Payment 1. MCPs were evaluated based on the set of measures they submitted as part of their Needs Assessment and Gap-Filling Plan to determine acceptance of Submission 1. Points for each measure were either credited in full, or not credited, unless the measure is noted as having a tiered evaluation approach. For the measures that are evaluated using a tiered approach, MCPs received the specified number of points within each tier for having completed the activity associated with each tier, as detailed in the Measure Set and Reporting Template. All other measures do not use a tiered approach and MCPs received either full or no credit for the measures. For counties where ECM and Community Supports have gone live as of June 30, 2022, Payment 2 measures that determine whether Payment 1 is fully earned are outlined in the Progress Report.[1] Please refer to the IPP All Plan Letter (APL) and IPP FAQ for more information.

[1] Applies only to counties where ECM and Community Supports have gone live as of June 30, 2022. For counties where ECM and Community Supports will not have gone live until July 1, 2022, performance improvement must be shown during the July – December 2022 reporting period.

IPP Payment 2

For Payment 2 and beyond, MCPs will submit Progress Reports to demonstrate their progress against the Gap-Filling Plans that were developed for Payment 1 submissions. All measures in the Progress Reports build on the requirements contained in the Needs Assessment, Gap-Filling Plan, and associated APL and are referenced, where appropriate, throughout. Before beginning work on the Progress Reports, MCPs should review these documents to ensure complete and robust responses.

End of Section

Evaluation Criteria

Measure Criteria

Payment to MCPs is based on the successful completion of reporting and performance against measures in the Progress Report. The Progress Report materials indicate performance targets and point allocations for each measure. MCPs may earn no, partial, or all points on measures, as indicated.

Each measure in the Progress Report is assigned to one of the following Program Priority Areas, with a fourth Quality Program Priority Area that is allocated between Priority Areas 2-3:

1. Delivery System Infrastructure;
2. ECM Provider Capacity Building; and
3. Community Supports Provider Capacity Building and Community Supports Take-Up

Points Structure

MCPs can earn a maximum of 1,000 points for Submission 2-A. If an MCP achieves only a subset of these points, it will earn a partial payment. A total of 700 points is assigned between the mandatory and optional[2] measures in Program Priority Areas 1-3. MCPs may allocate the remaining 300 points across Program Priority Areas 1-3; points from this discretionary allocation are earned proportionately based on performance.[3]

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[2] MCPs are required to report on a minimum number of optional measures.

[3] For example, if an MCP allocates 100 points to Priority Area 1 and earns 90% of the Priority Area 1 points, it will earn 90 of those 100 discretionary points.

(*Added Spring 2023*) MCPs will earn Payment 2 based on their total points achieved across Submission 2-A and Submission 2-B. MCPs can earn a maximum of 120 points for Submission 2-B. If an MCP achieves only a subset of these points, it will earn a partial payment. A total of 120 points is assigned to mandatory measures in Program Priority Areas 1-3.

MCPs must indicate their discretionary allocation distribution in their submission response for Submission 2-A *(does not need to be in table format)*. Allocations for this submission do not need to align with allocation ratios in other IPP submissions.

Priority Area	Mandatory Measures	Optional Quality Measures *(Priority Area #4)*	Discretionary Allocations
1. Delivery System Infrastructure	Up to **200** points	*None*	0
2. Enhanced Care Management (ECM) Provider Capacity Building	Up to **170** points	Up to **30** points	120
3. Community Supports Provider Capacity Building and Community Supports Take-Up	Up to **250** points	Up to **50** points	180
Category Totals	Up to **620** points	Up to **80** points	Up to **300** points
TOTAL	Up to **1,000** points		

DHCS may, at its sole discretion, consider granting exceptions in limited cases where the MCP makes a compelling request to DHCS to allocate more than 30% to the MCP's selected Program Priority Area (i.e., by allocating dollars from another priority area). MCPs requesting to allocate more than 300 points must respond to the following prompt; otherwise, leave blank:

(OPTIONAL) **Describe preferred allocation methodology, including how many points would be allocated to each measure (where different from above), and reason for requesting an allocation different from that above.** (100 word limit)

End of Section

Instructions

MCPs must submit the Submission 2-A Gap-Filling Progress Report to CalAIMECMILOS@dhcs.ca.gov by **Thursday, September 1, 2022**.

Please reach out to CalAIMECMILOS@dhcs.ca.gov if you have any questions. (*Added Spring 2023*) MCPs must submit the Submission 2-B Progress Report to CalAIMECMILOS@dhcs.ca.gov by March 15, 2023 for the measurement period beginning July 1, 2022 and ending December 31, 2022.

Progress Report Format

The Progress Report consists of two documents: the Narrative Report (as outlined in this Word document) and an accompanying Quantitative Reporting Template (Excel document). The Narrative Report includes Appendices A-B, which contain additional information, instructions, and references that are applicable to the Submission 2-A Progress Report.

For Submission 2-A, MCPs are required to submit responses to the measures noted as mandatory and for a minimum number of optional[4] measures. **MCPs are permitted and encouraged to work closely with providers and other local partners on these measures and any ongoing strategic planning.**

Sections that require MCPs to submit a response are indicated under each header in this document with the phrase *"Response Required to This Section."* No response is required from MCPs to any other sections.

For Submission 2-B, all measures are mandatory and MCPs are required to submit responses to all measures.

Narrative Responses

In response to the narrative measure prompts, MCPs should describe activities conducted during the measurement period of January 1, 2022 through June 30, 2022 for Submission 2-A, and during the measurement period of July 1, 2022 through December

[4] Refer to Appendix B for more information on responding to mandatory and optional measures.

31, 2022 for Submission 2-B (regardless of when the Gap-Filling Plan was submitted to and finalized with DHCS).

For several measures, attachments and supplemental information are required (e.g., meeting agendas). MCPs should include these attachments via email submissions.

For several measures, there are multipart narrative prompts within the measure. MCPs are required to respond to all parts of the question for their response to be considered complete.

For several measures, there are alternative narrative prompts within the measure to account for variances among counties (e.g., counties with and without recognized Tribes). MCPs must respond only to the question that is applicable to the county for which the Progress Report is being completed.

Quantitative Responses

MCPs must submit responses for quantitative measures within the accompanying Quantitative Reporting Template (Excel document). MCPs should read the Instructions tab, follow the prompts in the reporting template, and enter responses accordingly.

For several measures, MCPs may need to use publicly available data sources and complete their own calculations to respond to some measure prompts. Examples of data sources that may be helpful in MCP responses include:

Source	Description	Link
California Department of Finance	Demographic data by county	https://dof.ca.gov/forecasting/demographics/
California Business, Consumer Services, and Housing Agency	Homeless Data Integration System (HDIS), which provides data on homelessness by county	https://bcsh.ca.gov/calich/hdis.html

End of Section

Submission 2-A Measures for Priority Area 1: Delivery System Infrastructure

Response Required to This Section

2.1.1 Measure Description

Mandatory
40 Points Total
20 Points for the Quantitative Response
20 Points for the Narrative Response

Quantitative Response

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

Enter response in the Excel template.

Narrative Response

Describe the concrete steps taken and investments made by the MCP to increase the number of contracted ECM providers with HIE capabilities to electronically store, manage, and securely exchange health information and other clinical documents with other care team members (i.e., with other providers outside of the ECM's practice, clinic or care setting). (100 word limit)

Anthem and Plan partners shared IPP applications and submissions from joint providers.

Additionally, Anthem:

- Collected data through the certification/gap closure process on methods used by providers to support electronic care plan capabilities.
- Facilitated two provider webinars promoting IPP funding priorities, including IT system upgrades for HIE connectivity.
- Provided two trainings and semi-weekly office hours with providers on utilizing Anthem's Provider Portal to electronically store, manage, exchange care plan information.

- Anthem is prioritizing investments to local partners such as SFDPH and NEMS.

2.1.2 Measure Description

Mandatory
40 Points Total
20 Points for the Quantitative Response
20 Points for the Narrative Response

Quantitative Response

Number and percentage point increase in contracted ECM providers with access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan.

Enter response in the Excel template.

Narrative Response

Describe the concrete steps taken and investments made by the MCP to increase the number of contracted ECM providers with access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan. (100 word limit)

Anthem/Plan Partner collaborations:

Anticipates funding SFDPH Epic expansion, CBO access to CareLink.

Engaged with SFHP/local leadership around long-term goals of CHR and determined short-term solution is CareLink.

Additionally, Anthem:

- Collected data through the certification/gap closure process on methods used by providers to support electronic care plan capabilities.
- Facilitated two webinars promoting IPP funding priorities, including IT system upgrades for EHR

- Hosted two webinars about use of EHR by Anthem providers.
- Anthem is prioritizing investments to local partners such as SFDPH and NEMS.

2.1.3 Measure Description

Mandatory
40 Points Total
20 Points for the Quantitative Response
20 Points for the Narrative Response

Quantitative Response

Number and percentage point increase in contracted ECM and Community Supports providers capable of submitting a claim or invoice to a MCP, or have access to a system or service that can process and send a claim or invoice to a MCP with information necessary for the MCP to submit a compliant encounter to DHCS.

Enter response in the Excel template.

Narrative Response

Describe the concrete steps taken and investments made by the MCP to increase the number of contracted ECM and Community Supports providers capable of submitting a claim or invoice to a MCP, or have access to a system or service that can process and send a claim or invoice to a MCP with the information necessary for the MCP to submit a compliant encounter to DHCS. (100 word limit)

Anthem/Plan Partner collaborations:
Anticipates funding SFDPH Epic expansion, CBO access to CareLink.
Engaged with SFHP/local leadership around long-term goals of CHR and determined short-term solution is CareLink.
Additionally, Anthem:

- Collected data through the certification/gap closure process on methods used by providers to support electronic care plan capabilities.
- Facilitated two webinars promoting IPP funding priorities, including IT system upgrades for EHR

- Hosted two webinars about use of EHR by Anthem providers.
- Anthem is prioritizing investments to local partners such as SFDPH and NEMS.

2.1.4 Measure Description

Mandatory
20 Points

Quantitative Response Only

Number and percentage point increase in contracted Community Supports providers for those Community Supports offered by the MCP starting January 1, 2022, or July 1, 2022, with access to closed-loop referral systems.

Enter response in the Excel template.

2.1.5 Measure Description

Mandatory
20 Points

Quantitative Response Only

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).

Enter response in the Excel template.

2.1.6 Measure Description

Mandatory
10 Points

Narrative Response Only

Describe progress against Gap-Filling Plan regarding identification of underserved populations and the ECM providers to which they are assigned. Response should provide detail regarding which populations are underserved, the methodology used to identify them, the approach to assigning these members to an ECM provider, and any other relevant information regarding MCP activities completed and investments made. (100 word limit)

Anthem's Progress against the gap filling plan is:

- Identification of Underserved populations in the county: We have chosen to utilize the following publicly available data sources to help in the identification of underserved populations: Center for Health Policy Research (CHIS), The Homeless Data Integration System, DHCS 2020 Health Disparities Report, and the Community Health Needs Assessment. Discussions about underserved populations internally and externally with other MCP's and county partners has occurred. Examples of populations discussed include Medicaid eligible individuals needing mental health services, facing access to care issues, and populations needing SDOH support like housing. Anthem's Health Equity Director mined internal member data sources with respect to diagnoses related to maternity, SUD, Asthma, Diabetes, High Blood Pressure, Cardiovascular disease, and Mental Health data. The analysis concluded Black/AA SUD, Asian diabetes, and Asian preterm births are the top 3 statistically significant underserved populations in the county.
- Mining internal data methodology supports the publicly available data and has been developed through (1) a multi-source proprietary algorithm to identify ECM-eligible members and place them in a Population of Focus that best aligns with their needs. (2) ECM and CS provider referrals, member self-referrals, and other community referrals.
- Members are strategically assigned to ECM providers to support engagement with underserved populations by considering members' specific Population of Focus needs, previous provider relationships and member preference, geographic location, provider capacity, and cultural relevance of the provider to the member. To see the Providers Anthem members will be assigned to, Please see attachment " Anthem MOC Phase III ECM Provider Capacity 092022" Anthem has prioritized engagement with local providers who best represent their communities and have established trust with underserved populations.

- Nearly 60% of awarded IPP funds were granted to organizations operating in a single county or region
- Anthem has partnered with the San Francisco Department of Public Health, San Francisco Health Plan, as well as San Francisco's Continuum of Care to vet the gap filling plan and identify any gaps of care for ECM populations of focus.

2.1.7 Measure Description

Mandatory
10 Points

Narrative Response Only

Describe how the MCP successfully collaborated with all MCPs in the county to enhance and develop needed ECM and Community Supports infrastructure and, if applicable, leverage existing Whole Person Care (WPC) capacity. If only one MCP is operating in the county, the narrative must describe how it successfully leveraged and expanded existing county and, if applicable, WPC infrastructure to support infrastructure building. Response should include details regarding what barriers were encountered, which strategies proved successful, and the MCP's plans to continue infrastructure building. MCPs are also encouraged to describe how they might leverage the new community health workers (CHW) benefit moving forward to build capacity in the delivery system for ECM and Community Supports. (100 word limit)

Anthem continues to partner with key County stakeholders, including SFHN leadership, SFDPH partners, BH leads, the CoC housing leadership, and more to further develop WPC infrastructure for ECM and CS.

- Collaborative efforts include:
  - Joint steering committees, stakeholder round tables, trainings, certification application and gap closure discussions
  - MCO/MCO/Provider meetings
  - Sharing of contracted network provider lists between MCO's
  - Joint funding of IPP applications
  - Establishing processes for bi-directional data exchange and EHR's

- Barriers included time needed to educate providers, stakeholder capacity, time-intensive administrative requirements, lack of qualified licensed and non-licensed individuals who can staff ECM/CS positions.

- Anthem utilized IPP funding to support the implementation of CareLink, offering non-traditional provider access to Pop Health data, developing referral pathways from the county to CBO's

Ongoing successful strategies to address the barriers include:
- Frequent targeted outreach to local providers,
- Leveraging developed partnerships with other MCP's to collaborate on a streamlined IPP application process to minimize provider burden.
- Utilizing a Steering Committee model with County Account Management to ensure CalAIM is a topic of discussion within the county,
- Standing meetings with Plan partners to strategize roundtable agendas to ensure focused capacity expansion discussion continues and provider engagement does not decrease.
- Supporting ECM/CS infrastructure development and capacity-building with IPP funding by approving requests from San Francisco Department of Public Health and North East Medical Services to build or expand the current IT infrastructure at their organization and add staff.

Anthem contracts with ECM and CS Providers who have CHW staff serving members, similarly we will outreach to CHW Providers to determine their interest in becoming ECM and/or CS Providers. Anthem will provide education to providers on the guidelines for the CHW's scope of benefits and non-duplication of services. Those with access to the Provider Portal will be educated on how to view for enrollment flags. When CHW services are submitted, Anthem will review for potential duplication of services and notify referring entities immediately.

2.1.8 Measure Description

Mandatory
10 Points

Narrative Response Only

Describe any progress to build physical plant (e.g., sobering centers) or other physical infrastructure to support the launch and continued growth of ECM and Community Supports benefits. This response should provide detail regarding how the MCP has contributed to this infrastructure building, including but not limited to: financial contributions, participation in

planning committees, partnerships with other MCPs and other community entities engaged in infrastructure building, etc. Please exclude technology-related infrastructure (e.g., IT systems) from this response. (100 word limit)

Anthem:

- Continues discussions with County Agencies and local housing providers to strategize effective use of HHIP investments into county infrastructure,
- Continues discussions with local and regional providers to identify community priorities and solicit feedback to inform community-wide investments to support the build of physical plants (e.g., sobering centers) or other infrastructure to support successful implementation of ECM/CS.
- During the reporting period conducted Webinars to providers who are interested in offering physical infrastructure build out to support Enhanced Care Management and Community Support take up and education on the IPP Grant Application Process in San Francisco County.
- Implemented a 7-step process to prioritize proactive capacity building efforts with a focus on CS with physical infrastructure needs. For prioritized service gaps, Anthem is deploying development resources to identify and engage provider partners, understand needs (including physical infrastructure), and designate IPP funds to invest in start-up costs.

2.1.9 Measure Description

Mandatory
10 Points

Narrative Response & Materials Submission

Submission of a signed letter of collaboration, meeting agendas/notes, or other materials that outline the organizations with which the MCP collaborated in developing the Delivery System Infrastructure portion of the Gap-Filling Plan. If the MCP is unable to produce these documents, please specify why in the narrative response.

AND

Describe how all MCPs in the county vetted and iterated the Gap-Filling Plan with other local partners within the county. Response should include a list of organizations with which the MCP collaborated, completed activities, and methods of engagement. If no meaningful engagement or vetting with local partners was completed, please explain why and describe upcoming plans for vetting and iteration, including a list of proposed organizations, proposed activities, methods of engagement, and a time frame for completing these activities. (100 word limit)

Anthem collaborated with our Plan partners in San Francisco County to collect baseline data through the ECM/CS certification application and gap closure process and sent feedback document created for local partners to review/comment and send back about the plan. Anthem also vetted components of our gap filling plan to counties via email and iterated the plan during monthly CalAIM and San Francisco Health Plan bi-weekly meetings. Discussion includes the review of DHCS ECM and CS IT Infrastructure requirements as noted in DHCS Policy Guides, Plan specific provider guides ,and input into the ECM IT infrastructure requirements within the certification application for High Utilizers, SMI/SUD and Homeless PoF, network capacity, and gaps.

Additionally, Anthem has iterated components of the Gap Filling plan to Providers. Plan components iterated include Provider Portal data exchange methods and proper claims and encounter submissions with Providers at:

- Monthly Provider meetings with Anthem's clinical team to encourage utilization.
- Anthems monthly Provider webinar series.
- The cross-county collaboratives where we share best practices to Providers.
- A webinar educating Providers about the Value Based Payment Program which includes an encounter and claims metric.
- The certification application and gap closure process reviewing and ensuring the importance of bi-directional data exchange.

Anthem will continue to expand our vetting/stakeholder process which includes soliciting input on the plan through existing community forums/channels, such as:

- Behavioral Health Joint Operating Committee meetings,
- Monthly strategy/development meetings with SFDPH, SFHN, and SFHP.
- Anthem led weekly meetings with SFHP on capacity/expansion, CS county entity leads on delivery system infrastructure build and expansion, and collaborative stakeholder meetings that center specific PoF's (ie. reentry population, children/youth, people experiencing homelessness)
- Using social media/other community engagement channels to increase awareness of the existing Gap Filling Plan, Delivery System Infrastructure portion and how to access it. Establish a mechanism to receive feedback.
- Soliciting input on the plan through existing community forums and channels, such as SF County monthly meetings, weekly touch bases with SFHP, weekly meetings with county CoC, ongoing meetings with ECM/CS leads such as housing, sobering center and medical respite.

End of Section

Submission 2-A Measures for Priority Area 2: ECM Provider Capacity Building

Response Required to This Section

2.2.1 Measure Description

Mandatory
20 Points

Quantitative Response Only

Number of contracted ECM care team full time employees (FTEs).

Enter response in the Excel template.

2.2.2 Measure Description

Optional
Report on five (5) optional Payment 2 measures in Program Priority Area #2 to earn a total of 30 points

Quantitative Response Only

Reporting on racial and ethnic demographics of ECM care team FTEs for each Program Year 1 Populations of Focus relative to the racial and ethnic demographics of the beneficiaries in the Program Year 1 Populations of Focus.

Enter response in the Excel template.

2.2.3 Measure Description

Mandatory
20 Points

Quantitative Response Only

Number of Members receiving ECM.

Enter response in the Excel template.

2.2.4 Measure Description

Mandatory
10 Points

Quantitative Response Only

Number of Members across Program Year 1 Populations of Focus receiving ECM. Break out of Members across Program Year 1 Populations of Focus receiving ECM by race, ethnicity, and primary language.

ECM Populations of Focus for Year 1 / Calendar Year 2022 include:

- Individuals and Families Experiencing Homelessness
- High Utilizer Adults
- Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD)
- Adults and Children/Youth Transitioning from Incarceration (WPC Pilot counties only)

Enter response in the Excel template.

2.2.5 Measure Description

Mandatory
40 Points

Narrative Response Only

Narrative responses should outline progress and results from collaborations with local partners to achieve the below activities. (100 word limit per question below)

1. Describe what concrete steps have been taken and/or investments made to increase ECM provider capacity and MCP oversight capacity.
2. Describe what concrete steps have been taken and/or investments made to address ECM workforce, training, TA needs in county, including specific cultural competency needs by county.
3. Describe what concrete steps have been taken and/or investments made to support ECM provider workforce recruiting and hiring of necessary staff to build capacity.

4. List the MCP training and TA programs that have been provided to ECM providers, including details on when and where the trainings were held, how many people attended, and any organizations involved in the planning of training efforts. *NOTE: MCPs may submit relevant meeting minutes and attendee lists, training materials, and other attachments in lieu of a narrative response to Sub-Part 4*.

1. Part 1: Barriers identified towards increasing ECM provider capacity includes time constraints related to provider education and outreach about CalAIM, misinformation about CalAIM FQHC funding processes, impacts from staffing shortages in general and became worse by the Covid-19 pandemic.

Concrete Steps taken to address the barriers include:

- Frequent targeted outreach to local providers,
- Leveraging developed partnerships with other MCP's to collaborate on a streamlined IPP application process to minimize provider burden.
- Utilizing a Steering Committee model with County Account Management to ensure CalAIM is a topic of discussion within the county,
- Standing meetings with Plan partners to strategize roundtable agendas to ensure focused capacity expansion discussion continues and provider engagement does not decrease.
- Supporting ECM/CS infrastructure development and capacity-building with IPP funding by approving requests from North East Medical Services, School Health Clinics, and Gardner to build or expand the current IT infrastructure at their organization and add staff.

Specific methods of monitoring, oversight, and escalation are described to ECM providers in the ECM Provider Guide, Quality, Monitoring and Oversight section. Specifically, Anthem gives Providers a quarterly performance report to monitor progress across key measures, including the quality of the ECM assessment and care plan, member engagement and capacity expansion. A team of locally deployed Anthem clinical staff reviews the report with the ECM provider, and provides guidance, coaching and support to improve on those measures. In addition, Anthem established an ECM value-based program that will reward providers for measures such as successful member engagement, capacity expansion, and care management plan quality. This program includes regular ECM assessment and care plan audits.

2. Cultural Competency and TA needs were identified and shared with the county. Within this reporting period, the conversations with the County were primarily centered on educating what ECM and CS is, identification of providers who can serve these populations, and ECM provider readiness. Moving forward, Anthem will look for capacity within the county agenda to focus on and address cultural competency needs along with, workforce training, recruitment, and retention of staff with lived experience. Importantly, Anthem does assess Contracted Provider's LCM race and ethnicities to support a diverse ECM membership, engaged consultants and nearing a finalized contract to support building a model of care for the jail reentry population, and makes learning modules available free to providers that approach cultural competency in the framework within Behavioral Health, Case Management, and more:

- Technical Assistance needs were identified through provider questions directed to the Health Plan. To address this feedback Anthem:
- Updated ECM provider guides on DHCS and Anthem expectations and technical assistance guidance about ECM and notifies providers of these updates.
- Hosts webinars/cross county collaboratives/ reinforcing information Providers are needing assistance with.
- Office hours are held bi-weekly to support questions related to Anthems Provider Platform.
- 3 dedicated associate positions have been approved to support ECM providers with encounters, claims, and billing education and issue resolution.
- Continually updated ECM provider guides on expectations and technical assistance on ECM,
- Engaged consultants to support building a model of care for the jail reentry population.
- Hosted webinars/cross county collaboratives.

3. Examples of investments include $134892.02 to NEMS for Staff Training and Capacity Building, as well as funding to San Francisco Department of Public Health for IT Infrastructure developments and capacity building.

4. See attached.

2.2.6 Measure Description

Optional

Report on five (5) optional Payment 2 measures in Program Priority Area #2 to earn a total of 30 points

Narrative Response & Materials Submission

Narrative responses should outline progress and results from collaborations with local partners to achieve the below activities. Note that the strategic partnership requirements may be fulfilled through active and meaningful participation in the PATH Collaborative Planning Initiative—MCPs leveraging this must include details regarding any memoranda of understanding (MOUs), activities, and financial investments to support the PATH Collaborative Planning Initiative. (100 word limit per question below)

1. Describe progress against the narrative plan submitted for Payment 1 regarding the establishment and maintenance of strategic partnerships with MCPs in the county and other organizations *(see narrative measure 1.2.6, sub-question 2)*.
2. Describe progress against the narrative plan submitted for Payment 1 regarding addressing health disparities through strategic partnerships *(see narrative measure 1.2.6, sub-question 3)*.

AND

Submission of (1) MOUs or other collaborative agreements and (2) quarterly meeting agendas and notes (including a list of which organizations attended).

2.2.7 Measure Description

Mandatory
20 Points

Narrative Response & Materials Submission

MCPs must complete a narrative response for either of the prompt options below (and associated sub-components), as applicable. MCPs must also submit the required documents, as described below. (100 word limit)

1. Describe progress against the narrative plan submitted for Payment 1 regarding collaborative work with Tribes and Tribal providers used by members in the county to develop and support the provision of ECM services for members of Tribes in the county (*see narrative measure 1.2.7, sub-questions 2-3*). This response should include details on (1) concrete actions taken and investments made to demonstrate progress, (2) what issues have been identified in meetings facilitated to date, and (3) upcoming plans for meetings and other activities:
   a. Working with Tribes and Tribal providers used by members in the county on provider capacity.
   b. Providing ECM services for members of Tribes in the county.

OR

1. For MCPs operating in counties *without* recognized Tribes, describe the approach taken to supporting culturally competent ECM services for members who receive Tribal services, including efforts to contract with Tribal providers in surrounding counties.

AND

Submission of MOUs or other collaborative agreements and associated agendas and/or meeting notes.

• Anthem outreached to tribal providers and tribal organizations within our contracted counties to build upon existing relationships or form new ones that could potentially open doors to tribal providers and tribal organizations in this county. Anthem has been outreaching to and/or communicating with Chapa De, CRIHB, CCUIH, and MACT. Anthem Completed outreach attempts to Native American Health Center and Friendship House with the purpose to inform and educate about ECM and CS and share IPP opportunities.

• By Q4, Anthem will collaborate with our Plan partners to launch an Indian Health CalAIM Roundtable and promote ECM, CS and additional IPP grant funding opportunities specific to Tribes and Tribal Providers.

1a. Additionally, Anthem when applicable:
• Strategically prioritized outreach and follow-up to Tribes and Tribal providers.
• COVID in-person meeting limitations presented a challenge in engagement with providers lead by Tribal organizations that prefer in-person communication.

In San Francisco County, the Federally Recognized Tribes and tribal groups are people from the Muwekma, Ohlone, and confederated villages of Lisjan.

• 5 members who are Native American or Alaska Native enrolled in ECM in the reporting period.

2.2.8 Measure Description

Mandatory
20 Points

Narrative Response Only

Describe how the MCP successfully collaborated with all MCPs in the county to support ECM capacity expansion and, if applicable, leverage existing Whole Person Care (WPC) capacity. If only one MCP is operating in the county, the narrative must describe how it successfully leveraged and expanded existing county and, if applicable, WPC infrastructure to support ECM capacity building. Response should include details regarding what barriers were encountered, which strategies proved successful, and the MCP's plans to continue capacity and infrastructure building. MCPs are also encouraged to describe how they might leverage the new community health workers (CHW) benefit moving forward to build capacity in the delivery system for ECM. (100 word limit)

• Anthem continues collaborative efforts with SFHP at least twice a week to develop network strategy, county entity collaboration. Additionally, Anthem and SFHP support capacity expansion through:

- Certification application and gap closure discussions
- MCO/MCO/Provider meetings
- Sharing of contracted network provider lists between MCO's
- Joint funding of IPP applications

The Lead Entity is SFHN and SFDPH. From the beginning there has been engagement about supporting ECM capacity expansion.

Barriers included time needed to educate providers, stakeholder capacity, and lack of county-wide data sharing infrastructure.

Anthem contracts with ECM and CS Providers who have CHW staff serving members, similarly we will outreach to CHW Providers to determine their interest in becoming ECM and/or CS Providers. We will provide education to providers on the guidelines for the CHW's scope of benefits and non-duplication of services. Those with access to the Provider Portal will be educated on how to view for enrollment flags. When CHW services are submitted, Anthem will review for potential duplication of services and notify referring entities immediately.

2.2.9 Measure Description

Mandatory
20 Points

Quantitative Response

Baseline data for individuals who are Black/African American or from other racial and ethnic groups who are disproportionately[5] experiencing homelessness and who meet the Population of Focus definition: "people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions."

Enter response in the Excel template.

Narrative Response

Describe the steps taken to reach individuals who are Black/African American or from other racial and ethnic groups who are disproportionately experiencing homelessness and who meet the Population of Focus definition: "people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions." Response should include details on what barriers have been identified in reaching these populations as well as concrete steps taken/investments made to address these barriers, including partnerships with local partners. (100 word limit)

In San Francisco County, the top racial and ethnic groups disproportionately experiencing homelessness are:

- American Indian or Alaska Native
- Black or African American

[5] MCPs must determine which racial/ethnic groups disproportionately experience homelessness in the county, not just identify which racial/ethnic groups have the highest counts of homelessness. This will require some basic calculations using publicly available data.

- Native Hawaiian or Other Pacific Islander
- Hispanic/Latinx

Barriers to reaching these racial and ethnics groups are: Lack of housing to coordinate short term and long-term supportive housing services; Missing data on members experiencing homelessness, lack of accessible services to homeless individuals, the community in general is not aware of and are in need of education about the ECM benefit and CS services and how to access them, and low utilization of Z codes make it challenging for MCO's to identify homeless members.

To reach these Homeless Populations Anthem's concrete steps:

- Is using demographic data, z-codes, and public data, including the CDC's Social Vulnerability Index, in order to support eligibility determination, and prioritize eligible members for ECM outreach.
- Proactive algorithm specifically identifies Black/African American, as a risk factor for prioritization.
- Engaged HMIS across the state to improve homeless identification
- Hired a housing strategy team to focus on collaborating with local Continuums of Care and addressing inequities. This team addressed to internal Anthem associates and collaborative workgroups the fact that 21% of homeless are black compared to 12% within the general population and 36% of Anthem Members who are Black in San Francisco are homeless.
- Partnered closely with Homelessness and Supportive Housing agency to strategically develop and operationalize their Housing CBO network into Medicaid providers. Includes collaboratively designing a workplan and roll out that supports their capacity and long-term growth. We are also partnering on TA/education around billing, claims, referrals and authorizations.
- Collaborated with HSH to execute an MOU that would allow Anthem HMIS access, which would allow Anthem to better identify and support this population.

- Anthem's clinical team through the certification application process, ensure cultural competency training has been delivered. Special Programs staff members meet monthly with contracted providers and will share best practices, when available.

- Creating the ability to monitor provider outreach and engagement on a monthly basis and paying for improvement through the Value Based Payment Program

2.2.10 Measure Description

Optional

Report on five (5) optional Payment 2 measures in Program Priority Area #2 to earn a total of 30 points

Quantitative Response

Baseline data for individuals who are Black/African American or from other racial and ethnic groups who disproportionately[6] meet the Population of Focus definition ("individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community") and who have been successfully outreached to and engaged by an ECM provider.

Enter response in the Excel template.

Narrative Response

Describe the steps taken to reach individuals who are Black/African American or from other racial and ethnic groups who are disproportionately experiencing transitions from incarceration settings and meet the Population of Focus definition: "individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community." Response should include details on what barriers have been identified

[6] MCPs must determine which racial/ethnic groups disproportionately experience homelessness in the county, not just identify which racial/ethnic groups have the highest incarceration figures. This may require basic calculations using publicly available data or data obtained from county partners.

in reaching these populations and concrete steps taken/investments made to address these barriers, including partnerships with other community entities. (100 word limit)

- Engaged with a consultant to build a model of care for the jail reentry population, including engagement with the right stakeholders for successful in-reach and post release engagement. While the systems can be fragmented during this transition, Anthem is outreaching to all relevant stakeholders, such as the local Sheriff's department, Jail Health, Behavioral Health Services and SFHP through a Justice Involved workgroup.

- Stratified and prioritized member outreach based on risk factors, including race.

- Identified the need to engage a more representative provider network, prioritizing outreach to Black/African American lead providers, such as Jail Health, Behavioral Health, and SFHN ECM providers.

- Targeted engagement with behavioral health providers focused on individuals returning from incarceration.

2.2.11 Measure Description

Mandatory
10 Points

Quantitative Response Only

Number of contracted behavioral health full-time employees (FTEs)

Enter response in the Excel template.

2.2.12 Measure Description

Optional
Report on five (5) optional Payment 2 measures in Program Priority Area #2 to earn a total of 30 points

Narrative Response Only

Has the MCP hired a full-time Health Equity Officer by July 1, 2022, who has the necessary qualifications or training at the time of hire or within 1 year of hire to meet the requirements of the position, as outlined in the MCP Procurement?

Reply "YES" with the date of hire if this measure has been met.

OR

If this measure has not been met, reply "NO" with a description of concrete actions the MCP is taking to hire a full-time Health Equity Officer, including at a minimum (a) date when the job was posted, (b) how many candidates have been interviewed, and (c) how many job offers have been made to date. (100 word limit)

Anthem will not be reporting on this metric as one of the 5 optional Payment 2 measures.

2.2.13 Measure Description

Optional

Report on five (5) optional Payment 2 measures in Program Priority Area #2 to earn a total of 30 points

Quantitative Response Only

Plan 30-Day Readmissions (PCR)

For beneficiaries who are in the ECM Populations of Focus and between ages 18-64, the number of acute inpatient stays during the reporting period that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data is reported in the following categories:

- Count of Observed 30-Day Readmissions
- Count of Index Hospital Stays (IHS)

Enter response in the Excel template.

2.2.14 Measure Description

Optional

Report on five (5) optional Payment 2 measures in Program Priority Area #2 to earn a total of 30 points

Quantitative Response Only

Ambulatory Care—Emergency Department Visits (AMB)
Rate of emergency department (ED) visits per 1,000 beneficiary months for beneficiaries who are in the ECM Populations of Focus.

Enter response in the Excel template.

2.2.15 Measure Description

Optional

Report on five (5) optional Payment 2 measures in Program Priority Area #2 to earn a total of 30 points

Quantitative Response Only

Depression Screening and Follow-Up for Adolescents and Adults (DSF)
The percentage of beneficiaries 12 years of age and older who are in the ECM Populations of Focus and who were screened for clinical depression using a standardized tool and, if screened positive, who received follow-up care.

Enter response in the Excel template.

2.2.16 Measure Description

Optional

Report on five (5) optional Payment 2 measures in Program Priority Area #2 to earn a total of 30 points

Quantitative Response Only

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)
The percentage of members 12 years of age and older who are in the ECM Populations of Focus with a diagnosis of depression and who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.

Enter response in the Excel template.

2.2.17 Measure Description

Optional

Report on five (5) optional Payment 2 measures in Program Priority Area #2 to earn a total of 30 points

Quantitative Response Only

Follow-Up After Emergency Department Visit for Mental Illness (FUM)
Percentage of emergency department (ED) visits for beneficiaries age 18 and older who are in the ECM Populations of Focus and have a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported:

- Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)
- Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)

Enter response in the Excel template.

2.2.18 Measure Description

Optional

Report on five (5) optional Payment 2 measures in Program Priority Area #2 to earn a total of 30 points

Quantitative Response Only

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
Percentage of emergency department (ED) visits for beneficiaries age 18 and older who are in the ECM Populations of Focus and have a principal diagnosis of alcohol or other drug (AOD) abuse or dependence and who had a follow-up visit for AOD abuse or dependence. Two rates are reported:

- Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)
- Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)

Enter response in the Excel template.

2.2.19 Measure Description

Optional

Report on five (5) optional Payment 2 measures in Program Priority Area #2 to earn a total of 30 points

Quantitative Response Only

Controlling High Blood Pressure (CBP)
Percentage of beneficiaries ages 18 to 85 who are in the ECM Populations of Focus and who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mm Hg) during the reporting period.

Enter response in the Excel template.

2.2.20 Measure Description

Optional

Report on five (5) optional Payment 2 measures in Program Priority Area #2 to earn a total of 30 points

Quantitative Response Only

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
Percentage of children and adolescents ages 1 to 17 who are enrolled in the ECM Populations of Focus and who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:

- Percentage of children and adolescents on antipsychotics who received blood glucose testing
- Percentage of children and adolescents on antipsychotics who received cholesterol testing
- Percentage of children and adolescents on antipsychotics who received both blood glucose and cholesterol testing

Enter response in the Excel template.

2.2.21 Measure Description

Mandatory
10 Points

Narrative Response & Materials Submission

Submission of a signed letter of collaboration, meeting agendas/notes, or other materials that outline the organizations with which the MCP collaborated in developing the ECM Provider Capacity Building portion of the Gap-Filling Plan. If the MCP is unable to produce these documents, please specify why in the narrative response.

AND

Describe how all MCPs in the county vetted and iterated the Gap-Filling Plan with other local partners within the county. Response should include a list of organizations with which the MCP collaborated, completed activities, and methods of engagement. If no meaningful engagement or vetting with local partners was completed, please explain why and describe upcoming plans for vetting and iteration, including a list of proposed organizations, proposed activities, methods of engagement, and a time frame for completing these activities. (100 word limit)

Anthem collaborated with our Plan partners in San Francisco County to collect baseline data through:

- The ECM/CS certification application/gap closure process,
- County planning meetings,
- Created a feedback document for comment about the plan,
- Solicited input via email from County agencies.

Anthem will continue to expand our vetting/stakeholder process which includes soliciting input on the plan through community forums/channels, such as:

- BHJOC meetings,
- Strategy/development meetings with SFDPH, SFHN, and SFHP.

- Anthem led meetings with SFHP on capacity/expansion, CS county entity leads on delivery system infrastructure build/expansion, and collaborative stakeholder meetings that center specific PoF's (ie. reentry, children/youth, people experiencing homelessness)

End of Section

Submission 2-A Measures for Priority Area 3: Community Supports Provider Capacity Building & Take-Up

Response Required to This Section

2.3.1 Measure Description

Mandatory
30 Points

Quantitative Response Only

Number of and percentage of eligible Members receiving Community Supports and number of unique Community Supports received by Members.

Enter response in the Excel template.

2.3.2 Measure Description

Mandatory
30 Points

Quantitative Response Only

Number of contracted Community Supports providers.

Enter response in the Excel template.

2.3.3 Measure Description

Mandatory
35 Points

Narrative Response Only

Narrative should outline progress and results from collaborations with local partners within the county to achieve the below activities. (100 word limit for each question)

1. Describe steps taken to reduce gaps or limitations in Community Supports coverage across the county.
2. Describe steps taken to increase number and/or reach of Community Supports offered in January 2022 or July 2022.

Completing an in-depth CS network gap analysis and results showed STPH, Day habilitation, Medical Respite with no limitations in populations served are gaps.

Challenges to increasing the number and/or reach of CS include: Lack of local providers wanting to contract, clinical criteria required for specific CS services, cost associated with offering all care/clinical services encouraged by DHCS guidelines (particularly for Medical Respite and STPHH providers), limited time to outreach about CalAIM and impacts from staffing shortages in general and became worse by the Covid-19 pandemic

Steps to reduce gaps and increase the number of CS's offered are similar and include:

- Two webinars to educate stakeholders about CalAIM, the 14 Community Supports, and IPP funding opportunities to support provider development of new CS.

- Engaging with contracted providers to expand their services to additional counties.

- Completing an in-depth CS network gap analysis, prioritized the most challenging gaps, and deployed dedicated resources to identify and assist local providers in creating new CS offerings. Examples include meeting with SFDPH to go-live with Medical Respite, roll out a Sobering Center, and collaboratively work towards future CS services to offer, such as Housing services, Narcotic Sobering Center, and meals. Additionally, Anthem meets weekly with a county Lead Entity on CS specifically, to plan for implementation, expansion, and processes.

- Developing a CS provider guide, policies and procedures document, and reenforcing CS requirements during the certification application process.

- In the process of developing a CS value-based program that can reward specific CS providers for improvement in key areas such as member engagement.

- Engaged Anthem's Govt Relations Dir of Community Outreach to connect with contacts at AAA's, ILC's, ADRC's and other stakeholders to create opportunities for Anthem to provide education about Community Supports, the various CS provider types and how to become a CS provider

2.3.4 Measure Description

Mandatory
35 Points

Narrative Response Only

Narrative should outline progress and results from collaborations with local partners within the county to achieve the below activities. (100 word limit for each question)

1. Describe what concrete steps have been taken and/or investments made to increase Community Supports provider capacity and MCP oversight capability from January through June 2022.
2. Describe what concrete steps have been taken and/or investments made to address Community Supports workforce, training, and TA needs in region/county, including specific cultural competency needs by region/county.
3. Describe what concrete steps have been taken and/or investments made to support Community Supports workforce recruiting and hiring.
4. Please list the MCP training and TA programs that have been provided to Community Supports providers, including details on when and where the trainings were held, how many people attended, and any organizations involved in the planning. *NOTE: MCPs may submit relevant meeting minutes and attendee lists, training materials, and other attachments in lieu of a narrative response to Sub-Part 4.*

1. Anthem has prioritized STPH, Personal Care and Respite Services for provider capacity building efforts. Barriers identified towards increasing CS Provider capacity includes time constraints related to provider education and outreach about CalAIM and impacts from staffing shortages in general and became worse by the Covid-19 pandemic, lack of providers who can meet all the clinical components of specific CS. To increase provider capacity, Anthem has offered IPP funding, is in the process of developing a CS value-based program that will reward specific contracted CS providers for member engagement and other quality measures, and Anthem's Govt Relations Dir of Community Outreach to connect with contacts at AAA's, ILC's, ADRC's and other stakeholders to create opportunities for Anthem to provide education about Community Supports, the various CS provider types and how to become a CS provider.

To increase oversight capacity, Anthem has set aside resources to develop a CS value-based program that will reward providers for member engagement and quality of care. Currently Anthem is completing CS provider audits and monitoring CS provider staffing and capacity via regular reporting. Dedicated Anthem staff engage with CS providers about changes or updates to staffing and capacity levels.

2. To Support Technical Assistance and Cultural Competency Anthem:

- Anticipates awarding investments to SFDPH to improve data sharing capabilities for Medical Respite and Sobering Centers, improve IT infrastructure, and support capacity expansion. In total, Anthem is providing $134,892.02 for IT infrastructure and capacity expansion.

2.3.5 Measure Description

Mandatory
35 Points

Narrative Response Only

1. Describe progress against the narrative plan submitted for Payment 1 regarding collaborative work with Tribes and Tribal providers used by members in the county to develop and support the provision of Community Supports for members of Tribes in the county *(see narrative measure 1.3.6, sub-questions 2-3)*. This response should include details on concrete actions taken/investments made to demonstrate progress made in the below activities. (100 word limit)

a. Working with Tribes and Tribal providers used by members in the county on provider capacity.
b. Providing Community Supports for members of Tribes in the county.

OR

1. For MCPs operating in counties *without* recognized Tribes, describe the approach taken to supporting culturally competent Community Supports for members who receive Tribal services, including efforts to contract with Tribal providers in surrounding counties. (100 word limit)

• Anthem outreached to tribal providers and tribal organizations within our contracted counties to build upon existing relationships or form new ones that could potentially open doors to tribal providers and tribal organizations in

this county. Anthem has been outreaching to and/or communicating with Chapa De, CRIHB, CCUIH, and MACT. Anthem's concrete actions taken include:

- Completed outreach attempts to Native American Health Center and Friendship House with the purpose to inform and educate about ECM and CS and share IPP opportunities

- Partnered with the largest Safety Net provider in the county who cares for most vulnerable, including Native American, Indian American population.

- Working with the THE Collaborative to offer culturally competent TA support to providers.

- By Q4, Anthem will collaborate with our Plan partners to launch an Indian Health CalAIM Roundtable and promote ECM, CS and additional IPP grant funding opportunities specific to Tribes and Tribal Providers.

1a. Additionally, Anthem when applicable:

- Strategically prioritized outreach and follow-up to Tribes and Tribal providers.

- COVID in-person meeting limitations presented a challenge in engagement with providers lead by Tribal organizations that prefer in-person communication.

In San Francisco County, the Federally Recognized Tribes and tribal groups are people from the Muwekma, Ohlone, and confederated villages of Lisjan.

- 2 members who are Native American or Alaska Native enrolled in CS during the reporting period.

2.3.6 Measure Description

Mandatory
35 Points

Narrative Response Only

Describe how the MCP successfully collaborated with all MCPs in the county to support Community Supports capacity expansion and, if applicable, leverage existing WPC capacity. If only one MCP is operating in the county, the narrative must describe how it successfully leveraged and expanded existing county and, if applicable, WPC infrastructure to support Community Supports capacity building. Response should include details regarding what barriers were encountered, which strategies proved successful, and the MCP's plans to continue capacity and infrastructure building. MCPs are also encouraged to describe how they might leverage the new community health workers (CHW) benefit moving forward to build capacity in the delivery system for Community Supports. (100 word limit)

Anthem/SFHP continue collaborative efforts which started during WPC in preparation for CalAIM implementation:

- Co-designed the roll out plan with key stakeholders, including the county (SFDPH) and the local health plan.
    - For example, Anthem and SFHP met weekly with SFDPH and HSH to configure, build and explore ways to launch Housing CS services in a way that works for the county. The success of this effort is the county has a set go live date of July 2023.
- Address long-term strategies for county-wide data infrastructure.
    - Working closely with SFHP we have explored ways to improve data sharing beyond just excel flat files and beyond the small data set we currently can exchange. The success of this effort is that MCP's are bringing in key stakeholders to expand our population health data exchange options.
    - Actively working on using short-term data sharing solutions (including Carelink access). This expands capacity because now our medical respite and sobering center providers will not have the administrative burden of having to manually upload individual documentation. Anthem and SFHP's teams will be able to go into the record and view medical necessity/other requirements necessary.

- Offers hands-on support with CS stakeholders to overcome barriers in becoming a Medicaid provider, for example HSH, Medical Respite, Sobering Center. This includes MCP's designing invoicing and referral templates, reducing time consuming administrative work on providers, and allowing more direct services.

- Anthem will build a pipeline of referrals from deployed CHWs to CS programs through CHW education about CS's, direct support to access CS, and support navigating "Find Help". This will give CS providers more support around referrals and coordination.

Anthem identified CS capacity building barriers to include: time constraints related to provider education and outreach about CalAIM, misinformation about CalAIM FQHC funding processes, impacts from staffing shortages in general and became worse by Covid-19 pandemic, costliness of offering higher level of care/clinical services as encouraged by DHCS guidelines for CS services such as Personal Care, Respite and STPHH.

Ongoing successful strategies to address the barriers include:

- Frequent targeted outreach to local providers, as appropriate,

- Leveraging developed partnerships with other MCP's to collaborate on a streamlined IPP application process to minimize provider burden.

- Standing meetings with Plan partners to strategize roundtable agendas to ensure focused capacity expansion discussion continues and provider engagement does not decrease.

- Jointly supporting CS capacity-building and expansion efforts with IPP funding by approving qualified provider requests from local and regional CS providers.

Anthem contracts with ECM and CS Providers who have CHW staff serving members, similarly we will outreach to CHW Providers to determine their interest in becoming ECM and/or CS Providers. Anthem will provide education to providers on the guidelines for the CHW's scope of benefits and non-duplication of services. Those with access to the Provider Portal will be educated on how to view for enrollment flags. When CHW services are submitted, Anthem will review for potential duplication of services and notify referring entities immediately.

2.3.7 Measure Description

Mandatory
30 Points

Quantitative Response Only

Percentage of enrollees receiving Community Supports by race, ethnicity, and primary language, relative to the demographics in the underlying enrollee population.

Enter response in the Excel template.

2.3.8 Measure Description

Optional
Report on one (1) optional Payment 2 measure in Program Priority Area #3 to earn 50 points

Quantitative Response Only

Asthma Medication Ratio (AMR)
The percentage of beneficiaries ages 5 to 64 who are receiving Community Supports and who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the reporting period.

Enter response in the Excel template.

2.3.9 Measure Description

Optional
Report on one (1) optional Payment 2 measure in Program Priority Area #3 to earn 50 points

Quantitative Response Only

The number of individuals who meet the criteria for the Population of Focus ("people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions") who were housed for more than 6 consecutive months.

Enter response in the Excel template.

2.3.10 Measure Description

Optional
Report on one (1) optional Payment 2 measure in Program Priority Area #3 to earn 50 points

Quantitative Response Only

Controlling High Blood Pressure (CBP)
Percentage of beneficiaries who meet the criteria for the Population of Focus ("people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions") 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mm Hg).

Enter response in the Excel template.

2.3.11 Measure Description

Optional
Report on one (1) optional Payment 2 measure in Program Priority Area #3 to earn 50 points

Quantitative Response Only

Comprehensive Diabetes Care (CDC)
Percentage of beneficiaries who meet the criteria for the Population of Focus: "people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions," 18-75 years of age with diabetes who had hemoglobin A1c > 9.0%.

Enter response in the Excel template.

2.3.12 Measure Description

Mandatory
20 Points

Narrative Response & Materials Submission

Submission of a signed letter of collaboration, meeting agendas/notes, or other materials that outline the organizations with which the MCP collaborated in developing the Community Supports Provider Capacity Building and Community Supports Take-Up portion of the Gap-Filling Plan. If the MCP is unable to produce these documents, please specify why in the narrative response.

AND

Describe how all MCPs in the county vetted and iterated the Gap-Filling Plan with local partners within the county. This response should include a list of organizations with which the MCP collaborated, completed activities, and methods of engagement. If no meaningful engagement or vetting with local partners was completed, please explain why and describe upcoming plans for vetting and iteration, including a list of proposed organizations, proposed activities, methods of engagement, and a time frame for completing these activities. (100 word limit)

Anthem collaborated with our Plan partners in San Francisco County to collect baseline data through:

- The ECM/CS certification application/gap closure process,
- County planning meetings,
- Created a feedback document for comment about the plan,
- Solicited input via email from County agencies.

Anthem will continue to expand our vetting and stakeholder process which includes soliciting input on the plan and discussing the FUM/FUA measures through existing community forums and channels, such as Behavioral Health Joint Operating Committee meetings, monthly strategy and development meetings with SFDPH, SFHN, and SFHP directly to support CS implementation, navigate barriers, and work towards expansion.

End of Section

Submission 2-B Measures *(Added Spring 2023)*

Response Required to This Section

2B.1.1 Measure Description

10 Points

Quantitative Response

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

Enter response in the Excel template.

Narrative Response

Describe the concrete steps taken and investments made by the MCP to increase the number of contracted ECM providers that engage in bi-direction Health Information Exchange (HIE). *(No longer than one page per Measure)*

Anthem has developed and is executing a plan to improve the number of contracted ECM providers with certified HIE capabilities. This plan includes a focus improving the *input* into HIEs and the *use of outputs* from HIEs. During this reporting period, Anthem:

- *Improving input:*
    - Completed an internal assessment that showed only 25% of Anthem Providers across California (all lines of business) had ADT feeds available through HIEs. For Medicaid only 13% of Providers had ADT feeds available through Manifest, Anthem's preferred HIE.
    - Identified and began targeted outreach to 15 providers that – if connected – would increase ADT feed coverage by 53% across all counties. San Francisco County was one of the 15 providers prioritized.
    - By June 2023, Anthem's goal is to increase ADT coverage by 30% using Manifest, Experian, CMT and Bamboo Health.

- *Use of HIE output*
    - Providers were able to apply for IPP funding to support development of/access to certified HIE technology.
    - By June 2023, Anthem's goal is to:
        - Use PATH Collaboratives to discuss providers data exchange needs/priorities and assess how certified HIE systems could be leveraged to meet those needs.
        - Release at least one provider newsletter and one webinar on the topics of certified HIE and the CALHHS Data Exchange Framework. The goals of these materials will be to improve provider awareness of certified HIE benefits and increase providers that sign the CALHHS Data Exchange Framework Data Sharing Agreement.
        - In coordination with San Francisco Health Plan, Anthem will conduct a baseline assessment of current providers' access to and use of certified HIE technology. This assessment will include providers' understanding of the benefit of engagement with an HIE; perceived costs and barriers to access.

2B.1.2 Measure Description

20 Points

Quantitative Response

Number and percentage point increase in contracted ECM providers with access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan.

Enter response in the Excel template.

Narrative Response

Describe the concrete steps taken and investments made by the MCP to increase the number of contracted ECM providers with access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan. *(No longer than one page per Measure)*

As part of the application process, all prospective Anthem ECM providers receive individualized support from a dedicated Regional Program Manager (RPM). The provider's current use and needs related to their EHR/care management documentation system are discussed at length during this process. In the previous reporting period, providers that identified any needs related to their EHR/care management documentation system were directed to DHCS PATH CITED funding stream and Anthem's IPP application process, which had funding available to support these needs. In San Francisco during the reporting period, Anthem funded MasterCare to enhance their EHR/care management documentation capabilities. With that support MasterCare has completed the design of their care management (CM) platform, transferred PHI, and provided staff training. Additionally, the SFTP site was launched which included the report build. As a result, improvements were made to the reporting for OTF/RTF and allowances made for the import of new TEL/MIF and existing records.

While the vast majority of providers that applied to participate in ECM had some version of an existing EHR/care management documentation system, many providers needed support to optimize their platforms for use and interoperability within the ECM program. To support providers with these needs, during the reporting period, Anthem:

- Provided all prospective providers with a care plan template that captured all required care plan elements.
- Allowed for significant flexibility in the acceptable format for submitted care plans, allowing for required elements to be captured in a variety of ways (drop down, free text, etc.)
- Delivered live webinar training for all lead case managers on care plan development best practices, facilitated by nurses from Anthem's Clinical Care team. In the reporting period, 57 ECM Care Team Members serving San Francisco participated in this training.
- Maintained a backlog of educational webinars, open to all providers, including those on EHR use and care plan documentation. During this period 59 providers from San Francisco accessed webinars related to EHR use and care plan documentation.
- Provided monthly webinars and newsletters on various subjects, including EHR use and care plan documentation. During this period, relevant webinar and newsletter topics included transitions of care and engaging members with SMI, new care plan functionality in CareCentral, and Person Centered Planning training opportunities.

- Began developing a Provider training program that adheres to additional requests to enhance knowledge and expertise in providing best level of care for our members. Identified needs were collected through surveys and ongoing engagements with providers.

By June 2023, Anthem's goal is to:

- Research the ability for Anthem to share HEDIS data with ECM providers to support a comprehensive care plan and identify gaps in members preventive health care needs.
- Obtain legal approval for high priority Member Information File (MIF) enhancement that will allow for providers to securely import MIF data into their EHR, streamlining the care planning process.

2B.1.3 Measure Description

20 Points

Quantitative Response

Number and percentage point increase in contracted ECM and Community Supports providers capable of submitting a claim or invoice to a MCP, or have access to a system or service that can process and send a claim or invoice to a MCP with information necessary for the MCP to submit a compliant encounter to DHCS.

Enter response in the Excel template.

Narrative Response

Describe the concrete steps taken and investments made by the MCP to increase the number of contracted ECM and Community Supports providers capable of submitting a claim or invoice to a MCP, or have access to a system or service that can process and send a claim or invoice to a MCP with the information necessary for the MCP to submit a compliant encounter to DHCS. *(No longer than one page per Measure)*

All contracted providers are given access to CareCentral – Anthem's online provider portal through which – among other functions – all providers submit claims and invoices to Anthem. To ensure all providers can access and utilize the system with minimal barriers, between July 1 – December 2022 Anthem:

- Gave all providers personalized access to one of four Provider Network Consultants (PNC), dedicated to CalAIM providers, who provide technical assistance with a focus on claims & billing. PNCs have regular calls – sometimes weekly – with assigned providers.
- Maintained an internal, cross-functional Claims Workgroup where PNCs (and others) can surface, troubleshoot, and resolve provider claims or invoice issues. This group met bi-weekly throughout the reporting period.
- Anthem's platform was originally developed for use by smaller, community-based organization. Many of the system updates that Anthem has made during this process have been to support more claims and billing by larger providers.
- Instituted 22 claims or invoicing updates to CareCentral – at a direct cost of $1.2 M – to improve ease of use for ECM/CS providers. An example of an improvement made was creating a capability for providers to bulk upload member claims.
- Distributed a comprehensive CS/ECM provider guide, which is regularly updated, to all newly contracted CS/ECM providers. This guide covers the various uses of CareCentral, including claims and billing.
- Offered providers the option of developing an electronic billing interface, through which ECM/CS providers can bill Anthem via a direct feed from the provider EMR/EHR.
- Providers were able to utilize IPP funds to pay for electronic billing interface development or other upgrades to their claims and invoicing system, a total investment of $1,190,259. In San Francisco Anthem funded Serene Health to enhance their electronic billing capabilities. With that support Serene Health has implemented an enhanced care management (ECM) electronic billing module.
- Hosted twice a week technical office hours for providers that need additional assistance using CareCentral. From San Francisco, three (3) providers participated in at least one (1) office hours session during the reporting period.
- Maintained a backlog of educational webinars, open to all providers, including those on claims and invoicing. During this period three (3) providers (NEMS, San Francisco Health Network ECM and Titanium Healthcare) from San Francisco access webinars related to claims and invoicing.

By June 2023, Anthem's goal is to:

- Deploy PNC resources to provide dedicated one-on-one trainings on claims and billing.
- Increase awareness and attendance to the Care Central office hours

2B.1.4 Measure Description

20 Points

Quantitative Response Only

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.

NOTE: Closed-loop referrals are defined as coordinating and referring the 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 appropriate referred to, and received, services.

Enter response in the Excel template.

2B.2.1 Measure Description

10 Points

Quantitative Response Only

Number of contracted ECM care team full time equivalents (FTEs)

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.

Enter response in the Excel template.

2B.2.2 Measure Description

10 Points

Quantitative Response Only

Number of Members enrolled in ECM

Enter response in the Excel template.

2B.2.3 Measure Description

10 Points

Quantitative Response Only

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.

Enter response in the Excel template.

2B.3.1 Measure Description

10 Points

Quantitative Response Only

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

Enter response in the Excel template.

2B.3.2 Measure Description

10 Points

Quantitative Response Only

Number of contracted Community Supports providers.

Enter response in the Excel template.

End of Section