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	Central California Alliance for Health
MCP County	Santa Cruz
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*	*100*
2. Enhanced Care Management (ECM) Provider Capacity Building	Up to **170** points	Up to **30** points	*100*
3. Community Supports Provider Capacity Building and Community Supports Take-Up	Up to **250** points	Up to **50** points	*100*
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)

The Alliance has onboarded and trained ECM Providers in Activate Care, the Alliance's care coordination system for bi-directional data sharing. This system has been purchased and is being maintained by the Alliance for use by ECM providers. Live session trainings were held on Activate Care navigation and workflows, and three on-demand webinars are available to providers. Discovery in the vendor meetings with Activate Care revealed a challenge with integrating external EHR systems with Activate Care. For those not using Activate Care, the Alliance worked with provider individually to address their individual system needs, clarify data sharing requirements, and build a structured data template that could be used by all providers not using Activate Care. The Alliance has established unidirectional capability to share ECM member data with providers via SFTP sites. Structured templates have been developed with provider input to meet requirements and will be implemented at the end of Q322 to facilitate bidirectional data sharing. In Santa Cruz, three of

the four ECM providers have opted to use the Alliance's instance of Activate Care. The fourth provider has opted to manage ECM members in their existing EHR and to use incentive funding to build out their EHR for program requirements.

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)

During the network contracting process, providers were highly encouraged to adopt Activate Care, the Alliance's care coordination system, as their EHR for ECM implementation. This system has been purchased and is being maintained by the Alliance for use by ECM and Community Supports providers. The Alliance has onboarded and trained those providers who are using Activate Care on the system navigation, care plan template and workflows. The uptake has been mostly with smaller community-based organizations. Some of the larger organizations opted to continue to use their EHR which were vetted to meet care plan management capabilities. The Alliance worked with those providers to ensure that all required elements were included in their care plan template. Incentive funding supported Santa Cruz County Health Services Agency (SCCHSA) in transitioning from their own instance of Activate Care to the Alliance's instance which required a one-time data exchange through Santa Cruz Health Information Organization.

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)

Newly contracted ECM and CS providers receive a New Provider Orientation with detailed instructions about billing. A Claims/Invoicing Provider Training is available as an on-demand webinar. Ongoing Provider Relations Representative support and troubleshooting is available for any billing issues that arise. Providers who lack the technical abilities to submit claims may bill for services by invoice via SFTP using Alliance-provided invoice template. Incentive funding has been made available, when need was identified by providers, to support administrative staff to set up systems, enhance existing systems and to ensure proper billing and HIPAA compliance

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)

IT infrastructure/workflows were established prior to ECM implementation to assign members to providers. The Alliance intakes information from ECM providers about underserved populations identified by their organizations. Providers have identified specific racial/ethnic groups, people living with disabilities, mental health and substance use conditions,

individuals experiencing homelessness, seniors and monolingual non-English speakers as underserved populations. The Alliance will engage in more complex data stratification for targeted outreach for these populations. The Alliance has trained providers and informed broader community partners and members on the "no wrong door" ECM referral process. An ECM Quality Program Advisor position has been added, dedicated to data analysis to support efforts to develop eligible member lists and special reports (upon provider request, inclusive of race/ethnicity data). The Alliance identifies underserved members through risk stratification, incorporating factors such as members' medical and behavioral health utilization data, demographic data including race/ethnicity and homelessness, health risks and predictive cost and care needs index.

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)

The Alliance worked with Santa Cruz County Health Services Agency (SCCHSA) to successfully transition WPC enrollees to ECM. The Alliance leveraged the existing data systems utilized by Santa Cruz County WPC to transition to the Activate Care software. The Alliance provided incentive funding to support data exchange solutions to meet ECM requirements, and internal data sharing for the County between the clinic and behavioral health EHRs. Incentive funding supported WPC administration staff transitioning to ECM program set up, including policies and procedures development, staff supervision, invoicing, and reporting. Hiring and retention of CHWs on the ECM care team has also been incentivized. We await final DHCS guidance on how providers will determine billing for ECM vs. CHW benefit when provided by a CHW on an ECM care team. SCCHSA is using the Alliance's instance of Activate Care. The Alliance worked with Santa Cruz

Health Information Organization to integrate ED visit alerts into the Alliance's instance of Activate Care.

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)

Transportation for ECM clients was identified as an infrastructure need. Incentive funding supported the purchase of two (2) vehicles for use by Santa Cruz County Health Services Agency's ECM team. Discussions have been held with provider in Santa Cruz toward Spring 2023 Sobering Center implementation led by the County. The provider will need to bid to be the operator of the Sobering Center before it can contract with the Alliance for CS services. Additional discussions are being held with the contracted provider and County Housing for Health division regarding incentive funding for an expansion of recuperative care and STPHH through repurposing an available motel. Incentive funding was used for physical workspace equipment for a Community Supports provider.

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)

The Alliance engaged with each contracted (or soon to be) provider at several levels during the contracting phase to address the gap identified in assessment of their electronic and data capabilities. For each contracted provider, a detailed process was followed that included Certification Tool (readiness) assessment, Infrastructure Needs Form review, and detailed follow up communications (phone/email) to collaboratively develop funding milestone that meets each providers' specific needs for execution in the IPP Letter of Agreement. The Alliance has individual LOAs and supporting documentation on file. The Alliance further incentivized IT system training for individual providers if need was not met by existing training through the Alliance's contracted training consultant.

In addition, the Alliance's ECM/CS Network Development Team engaged with providers in regular engagement session, bi-weekly meetings, and monthly county collaborative meetings. Insights from providers during these meetings were integrated into the IPP gap filling plan. The Alliance has also engaged providers in set up and implementation of the care coordination system and the closed loop referral system for community resources, all of which the Alliance has investing in contracting and ongoing oversight and maintenance.
See Attachment 2 - ECM/ CS Provider Meetings January – June 2022.
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. Regarding ECM provider capacity, the primary work in the first six months of implementation has been incentivizing providers to hire and train direct service staff to increase enrollment of ECM members and engage members in the ECM and supportive services, and assessment and development of personcentered care plans. Incentive funding supported administrative staff to develop policies, processes and workflows for ECM program administration, and IT investments. Incentive funding Letters of Agreement (LOAs) were executed that outlined specific milestones in specific funding categories of workforce, IT systems, training, program development/oversight and other equipment/infrastructure to be reported on at the end of the incentive period. In Santa Cruz, five ECM provider incentive LOAs were executed and one was under development.

2. Regarding ECM training and TA, the Alliance contracted with Health Management Associates (HMA) to provide a multi-modal training program that focused on expertise in culturally competent, community-based, face to face service delivery, as well as the ability to meet core service delivery components. The program included four components: Activate Care Training, Webinar Series, Quarterly Learning Sessions, and Practice Coaching. HMA leveraged the ECM providers' existing capacity in serving the populations of focus to facilitate a collaborate learning community. The topics for upcoming webinars were identified by providers, including complex medical conditions and homelessness, housing readiness, and MH and SUD basics. Individual coaching was provided to two ECM care teams in Santa Cruz County.

3. Workforce development was the primary need identified by providers to support recruitment and hiring of ECM and Community Supports staff and was the largest investment category for incentive administration. In Santa Cruz, 70% of incentive funding was for workforce, the majority for direct service positions of Care Managers, Mental Health Client Specialists, Community Health Workers, Clinical Supervisors, Registered Nurses, Social Workers, Care Coordinators, and Peer Support Specialists. In progress reports received to date, providers are on track to hire intended number and types of positions. Final reports on staffing

milestone completion for the first round of incentive funding are due between January and June 2023 depending on when LOA was executed.

4. See Attachment 3 for ECM/CS Training Program Activities January – June 2022.

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.

At present there are no Tribal clinics within our service area. Should a Tribal clinic join our service area, or should our service area expand to include a county in which a Tribal clinic operates, the Alliance would pursue contracting efforts with any/all Tribal clinic partners, including for ECM services. There were no identified American Indian ECM enrollees in the reporting period. To the extent that an AI/AN member wishes to seek services through an out of area tribal provider, the Alliance would engage in necessary conversations to ensure that such services remained accessible and afforded to such members. As the need for Tribal services has not been identified at this time for health care services and ECM supports, the Alliance would focus efforts on these partnerships at a later time when such need is identified. The Alliance contracts with a diverse network of providers whom, to date, has met the needs of enrolled members. Future need may be influenced by Service Area expansion, when the volume of AI/AN members might increase. We have not been aware to

date of patterns of access to tribal services that would warrant contract exploration. The Alliance looks forward to future ECM provider training on culturally competent care and participating in the PATH Collaborative to identify new opportunities to use incentive funding in support of culturally competent ECM services.

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)

The Alliance worked with Santa Cruz County Health Services Agency (SCCHSA) to successfully transition WPC enrollees to ECM, leveraging the County's existing staffing expertise and experience in case management program implementation. The Alliance provided incentive funding to transition SCCHSA's Whole Person Care administration staff to the ECM program to set up and maintain ECM services. Hiring and retention of CHWs on the ECM care team has also been incentivized. We await final DHCS guidance on how providers will determine billing for ECM vs. CHW benefit when provided by a CHW on an ECM care team. The Alliance has also funded a training series for ECM staff with a focus on CHW competencies.

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)

The Providers are beginning to build their ECM teams and workflows, including referral process in order to identify and enroll eligible members. The Alliance has worked with providers to develop eligible member lists as requested by providers to target ECM outreach, including race/ethnicity and homelessness identifiers. In the first six months of implementation on 1/1/22, contracted ECM providers have enrolled 18% of the identified Black/African-American eligible members, but none of the very low number of identified Native American/Alaska Native eligible members. Individuals identified as Black and African American and Native American/Alaska Native tend to be in the system longer when compared to Non-Hispanic and non-transition age youth White individuals, indicating need for experienced case workers who can effectively navigate the social services system. Lack of trust among ethnic groups, including multiracial groups, who disproportionately experience homelessness is a larger societal issue. Both of these issues have been identified as topics for future ECM provider trainings and are mitigated through the hiring qualified staff. In working with the County,

[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.

CoC and service providers in Santa Cruz County, the focus has been on incentivizing hiring of culturally responsive staff, including Community Health Workers reflective of the population. We are aligning with the needs identified by the CoC through HHIP planning process to promote strategies across providers, such as participation of community members with lived experience on the CoC board and increasing street outreach. The Alliance looks forward to participating in the PATH Collaborative with community providers and State SMEs to identify new strategies in support of targeted service delivery for members who are Black/African American, Native American/Alaska Native and multiracial.

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)

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)

Optional – Not reporting on this measure.

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)

The Alliance completed the Gap Filling Plan based primarily on the information provided by community partners through engagement sessions, individual contracting meetings, and individual incentive planning meetings. The Alliance was engaged in extensive informing activities with county agencies and community-based organizations regarding gaps and barriers they identified and were seeking to fill through incentive funding. From January through June, the Alliance engaged with each interested provider in individual meetings during the contracting phase to address the gaps identified in their readiness assessment. For each contracted (or soon to be) provider, a detailed process was followed to collaboratively develop incentive funding milestones with an aim toward filling gaps identified, with a specific focus on workforce, training, programmatic development, IT infrastructure and data sharing. In a preliminary IPP progress report, SCCHSA reported that since January 2022, the ECM administrative staff attended 38 meetings or trainings facilitated by the Alliance or Health Management Associates. The Alliance looks forward to participating in the PATH Collaborative as an organized forum for vetting and iterating the Gap Filling Plan with community partners. The work ahead is to identify new organizations and reengage those who were not ready in first half of 2022 to continue to close gaps and to increase capacity of existing contracted providers. See Attachment 4 – Providers Engaged in IPP Gap-Filling.

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.

1. The Alliance launched Medically Tailored Meals as a Community Supports and aligned the eligibility criteria with that of the prior Alliance-only benefit which accepts referrals post-discharge for specific conditions. As part of the Community Supports phasing planning, the Alliance has identified opportunities with the MTM provider to expand to additional subpopulations and medical conditions as suggested by DHCS. The Alliance transitioned existing recuperative care and short-term post-hospitalization housing providers from an Alliance grant-funded pilot program started in March 2021 to be ready for Community Supports service delivery implementation on July 1, 2022. The Alliance will offer this CS initially with the service restriction of only receiving referrals from recuperative care facilities. Community organizations are being identified to be a referring agencies when existing provider capacity is increased after launch.

2. The Alliance added three new Community Supports housing service providers to the network between January and June and provided funding for housing service providers to hire staff and build infrastructure to serve more members. Alliance staff, with DHCS approval, had to support the gap for housing navigation services for a short period of time when CS providers reached capacity, prior to additional CS providers being contracted after this reporting period. Discussions have been held with a provider in Santa Cruz toward a Spring 2023 Sobering Center implementation led by the County. The community provider will need to bid to be the operator of the Sobering Center before it can contract with the Alliance for CS services. Additional discussions are being held with the contracted recuperative care and STPHH provider and County Housing for Health division regarding incentive funding for an expansion of recuperative care and STPHH beds through repurposing an available motel.

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. Regarding CS provider capacity, the primary work in the first six months of implementation has been incentivizing providers to hire and train direct service staff to increase enrollment of members in supportive services, Incentive funding also supported administrative staff to develop policies, processes and workflows for program administration, in addition to IT investments. Incentive funding Letters of Agreement (LOAs) were executed that outlined specific milestones in specific funding categories of workforce, IT systems, training, program development/oversight and other equipment/infrastructure to be reported on at the end of the incentive period. In Santa Cruz, four CS provider incentive LOAs were executed and one was under development.

2. Regarding Community Supports training and TA, the Alliance contracted with Health Management Associates (HMA) to provide a multi-modal training program that focused on culturally competent, community-based, face to face service delivery and best practices, as well as the ability to meet core service delivery components. As there is overlap between many of the ECM and CS providers, and in an effort to provide the most robust training offerings, the Alliance made all training modules available to CS providers. The program included four components: Activate Care Training (which some Community Supports providers have also elected to use for member management), Webinar Series, Quarterly Learning Sessions, and Practice Coaching. HMA leveraged the ECM providers' existing capacity in serving the populations of focus to facilitate a collaborate learning community. The topics for upcoming webinars were identified by providers, including complex medical conditions and homelessness, housing readiness, and MH and SUD basics. Individual coaching was provided to two Community Supports services teams in Santa Cruz County.

3. Workforce development was the primary need identified by providers to support recruitment and hiring of ECM and Community Supports staff and was the largest investment category for incentive administration. In Santa Cruz, 70% of incentive funding was for workforce, which included support Community Health Workers and Peer Support Specialists. Incentive funding is under development for Housing Navigators for an additional provider. In progress reports received to date, providers are on track to hire intended number and types of positions. Final reports on staffing milestone completion for the first round of incentive funding are due between January and June 2023 depending on when LOA was executed.

4. See Attachment 3 for ECM/CS Training Program Activities January – June 2022.

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)

At present there are no Tribal clinics within our service area. Should a Tribal clinic join our service area or should our service area expand to include a county in which a Tribal clinic operates, the Alliance would pursue contracting efforts with any/all Tribal clinic partners, including for CS services. There were no identified American Indian CS enrollees in the reporting period. To the extent that an AI/AN member wishes to seek services through an out of area tribal provider, the Alliance would engage in necessary conversations to ensure that such services remained accessible and afforded to such

members. As the need for Tribal services has not been identified at this time for health care services and CS services, the Alliance would focus efforts on these partnerships at a later time when such need is identified. The Alliance contracts with a diverse network of providers whom, to date, has met the needs of enrolled members. Future need may be influenced by Service Area expansion, when the volume of AI/AN members might increase. We have not been aware to date of patterns of access to tribal services that would warrant contract exploration. The Alliance looks forward to future CS provider training on culturally competent care and participating in the PATH Collaborative to identify new opportunities to use incentive funding in support of culturally competent CS services.

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)

The Alliance worked with Santa Cruz County Health Services Agency (SCCHSA) to identify that all support services offered under WPC were successfully transitioned under Community Supports. County staff leveraged their County's existing staffing expertise and experience in assessment and referral to supportive service to engage housing support providers in particular. The Alliance provided incentive funding to transition SCCHSA's Whole Person Care administration staff to the ECM program to set up and maintain ECM services, including referral workflows for CS supportive services. The Alliance has also engaged providers in use of Unite Us, the closed loop referral system for community resources in which the Alliance has invested in contracting, ongoing oversight and maintenance and provider training. The Alliance plans to continue to identify CS providers, particularly for the housing suite of CS services. The Alliance has been in discussions with prospective and contracting providers about strategies to support CHW workforce development in Santa Cruz

County, including participation Santa Cruz County Health Workforce Council. The Alliance has provided incentive funding for the hiring and training of CHWs for culturally service delivery. Building out opportunities for hiring CHWs at clinics already in the network as well new community-based organizations to deliver the CHW benefit may be opportunities to engage these organizations to also become Community Supports providers where applicable, to leverage the two revenue streams and provide enhanced, coordinated care for CS eligible members. Strong provider education will be necessary to ensure that contracted providers know how to appropriately bill.

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)

The Alliance completed the Gap Filling Plan based primarily on the information provided by community partners through engagement sessions, individual contracting meetings, and individual incentive planning meetings. The Alliance was engaged in extensive informing activities with county agencies and community-based organizations regarding gaps and barriers they identified, and were seeking to fill through incentive funding. From January through June, the Alliance engaged with each interested provider in individual meetings during the contracting phase to address the gaps identified in their readiness assessment. For each contracted (or soon to be) provider, a detailed process was followed to collaboratively develop incentive funding milestones with an aim toward filling gaps identified, with a specific focus on

workforce, training, programmatic development, IT infrastructure and data sharing. The Alliance looks forward to participating in the PATH Collaborative as an organized forum for vetting and iterating the Gap Filling Plan with community partners. The work ahead is to identify new organizations and reengage those who were not ready in first half of 2022 to continue to close gaps and to increase capacity of existing contracted providers. See Attachment 4 – Providers Engaged in IPP Gap-Filling.

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)*

Plan Response:

To facilitate bi-directional Health Information Exchange (HIE), the Central California Alliance for Health (the Alliance) offers ECM Providers in Santa Cruz County access to one of two optional care management platforms (Activate Care and Unite Us), or an alternate EHR or care coordination software platform of their choosing.

For those ECM Providers who have opted in, the Alliance has onboarded and trained providers in Activate Care, the Alliance's secure web-based care coordination software platform for bi-directional data sharing. This system has been purchased and is being maintained by the Alliance for optional use by ECM providers. The platform allows ECM providers to manage records of members receiving ECM, including member data sharing authorizations disclosing personally identifiable information between the Alliance, ECM provider, and other providers, whether the information is obtained by the Alliance, or an ECM provider. Live session trainings were held on Activate Care navigation and workflows, and three on-demand webinars are available to providers.

In addition, Unite Us can also be utilized as an optional care-management software platform for providers in Santa Cruz County. The Alliance utilizes provider data from either Activate Care or Unite Us to receive ECM provider encounters, which is combined with claims information, to submit ECM supplemental and quarterly implementation monitoring reports to DHCS.

For those providers not using Activate Care or Unite Us, the Alliance worked with providers individually to address their unique system needs, clarify data sharing requirements and build structured data templates, which were implemented at the end of Q322. The Alliance established unidirectional capability to share ECM member data with providers via SFTP sites. If the supplemental report has claims and encounter data, there is an automated process to consume and process the claim or invoice and transmit as encounter data to DHCS. If the supplemental report is not claim's related, the report is being processed manually. This is a gap as we work on the automated process documented above.

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)*

Plan Response:

During the network contracting process, providers were highly encouraged to adopt Activate Care, the Alliance's care coordination system, as their EHR for ECM implementation. This system has been purchased and is being maintained by the Alliance for use by ECM and Community Supports providers. The Alliance has onboarded and trained those providers who are using Activate Care on the system navigation, care plan template and workflows. The uptake has been mostly with smaller community-based organizations. In addition, Unite Us can also be utilized as an optional care-management software platform for providers in Merced County. The Alliance utilizes provider data from either Activate Care or Unite Us to receive ECM provider encounters, which is combined with claims information, to submit ECM supplemental and quarterly implementation monitoring reports to DHCS.

Some of the larger organizations opted to continue to use their EHR which were vetted to meet care plan management capabilities. The Alliance worked with those providers to ensure that all required elements were included in their care plan template. Incentive funding supported: Santa Cruz County Health Services Agency (SCCHSA) in transitioning from their own instance of Activate Care to the Alliance's instance which required a one-time data exchange through Santa Cruz Health Information Organization; Salud Para La Gente in designing and establishing interfaces between Activate Care and Unite Us with Salud's electronic medical record (EMR), Intergy by Greenway, and develop reporting solutions to meet Salud's needs for care coordination and ECM documentation; Santa Cruz Community Health Centers to integrate Unite Us as a closed-loop referral platform into eClinical Works; and Independent Living Systems to implement an enhanced interface to support automation of member information file transmission and import into eCare, ILS' member information platform.

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)*

Plan Response:

The Alliance currently has the IT infrastructure in place to consume and use claims and encounter data, assign members to Community Supports Providers, receive and process claims/invoices and transmit to DHCS, receive and process supplemental reports from Community Supports Providers, and send supplemental reports to DHCS as follows. The clinical data system assigns members to Community Supports providers through the use of authorizations. Data from the Alliance's claims processing system and clinical information system are pulled into the encounter data warehouse to enable supplemental reporting to DHCS. Plan data is also consumed by the Alliance's Market Basket system, which is used to risk stratify members and provide member-specific information such as gaps in care, medication conditions, and severity of illness and comorbidities.

Newly contracted ECM and CS providers receive a New Provider Orientation with detailed instructions about billing. A Claims/Invoicing Provider Training is available as an on-demand webinar. Ongoing Provider Relations Representative support and troubleshooting is available for any billing issues that arise. Providers who lack the technical abilities to submit claims may bill for services by invoice via SFTP using Alliance-provided invoice template. Incentive funding has been made available, when need was identified by providers, to support administrative staff to set up systems, enhance existing systems and to ensure proper billing and HIPAA compliance to prepare for January 1, 2023, implementation.

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