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	AIDS Healthcare Foundation (AHF) dba PHC California
MCP County	Los Angeles
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*	*150*
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	*50*
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)

Prior to the rollout of ECM, DHCS approved AHF's request that its existing Care Management Department serve as the ECM provider for its enrollees. Because AHF operates an AIDS special needs MCP, since its inception, AHF has provided care management services to all enrollees. The amount of Care Team attention is based on assessed severity level and care plan developed in partnership with enrollees' PCPs. AHF's Care Management staff is able to provide lower level (non-ECM) care management services and ECM services to its current census. At this time, AHF does not intend to contract with outside ECM providers in the future. Should the MCP's census increase, it will hire additional RN Care Team Managers and Community Health Workers to staff ECM operations.

AHF contracted with the Los Angeles Network for Enhanced Services (LANES) as its HIE. Care Management staff review LANES data daily for MCP enrollee encounters/admissions. They load these encounters into the MCP's care management medical record, eQSuite. In addition, the majority of PCPs in the MCP's provider network are AHF Healthcare Center providers. Care Management team members have access to the EHR of enrollees who are assigned to AHF PCPs. Care Management teams are also able to load care management notes into enrollees' EHRs so there is a feedback loop to AHF PCPs.

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)

As part of the MCP taking on ECM for its enrollees, AHF invested approximately $20K in building out an ECM module in its care management medical record, eQSuite. The ECM module allows AHF's ECM RNs and CHWs to record enrollee consent for ECM, their time spent on each enrollee by modality, i.e., in-person or telephonic encounter, documentation of encounter, progress notes, encounters from HIE, care plan, etc. Data from the ECM model is exported on a monthly basis for creation of encounter data, which the MCP submits to DHCS.

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)

For ECM, the MCP submits encounter data generated that its EDI staff is pulls from its care management medical record system. ECM staff log their encounters in the ECM module of eQSuite. For the MCP's housing transition navigation and housing tenancy and sustaining services providers, the MCP provided these providers with an invoice template and instructions on how to invoice the MCP using DHCS-approved HCPCs for the services they provide. The MCP converts invoices into reportable encounters for submission to DHCS. For the meals and personal care service providers, they submit electronic claims to the MCP using HCPCs specified in their contracts with the MCP. The MCP submits these encounters to DHCS.

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)

The MCP uses the sources of data noted below to identify enrollees who may fall into the following underserved populations. Should any enrollee fit into any of these populations of focus, the MCP's Care Management team will make multiple attempts to secure enrollee consent to expand care management services to ECM. Regardless of the population of focus, the MCP's Care Management team will provide ECM services to ECM eligible enrollees.

1. Individuals and families experiencing homelessness – Encounter data looking for diagnosis code Z59.0, care management EHR notes regarding enrollee housing situation, and (for enrollees assigned to an AHF Healthcare Center PCP) EHR patient history and diagnoses.
2. Adult high-utilizers – Encounter data, i.e., emergency department, inpatient, HIE data, care management EHR documentation, and (for enrollees assigned to an AHF Healthcare Center PCP) EHR patient history and diagnoses.
3. Adult serious mental illness (SMI/SUD) – Encounter data, HIE data, care management EHR documentation, care management documentation from and biweekly rounds with the MCP's behavioural health provider (Magellan) and (for enrollees assigned to an AHF Healthcare Center PCP) EHR patient history and diagnoses.
4. Individuals transitioning from incarceration - Encounter data looking for diagnosis codes Z65.0 and Z65.1, care management EHR notes regarding enrollee incarceration history, and (for enrollees assigned to an AHF Healthcare Center PCP) EHR patient history.
5. Individuals at risk for institutionalization and eligible for long-term care services - Encounter data, i.e., emergency department, inpatient and SNF admissions, HIE data, care management EHR documentation and health assessment severity rating, and (for enrollees assigned to an AHF Healthcare Center PCP) EHR patient history and diagnoses.
6. Nursing facility residents who want to transition into the community - Encounter data, PASRR process documentation and care management HER documentation and health assessment severity rating.

The MCP is building reporting tools internally to capture diagnosis codes from encounter data and AHF Healthcare EHR data for Care Management to more efficiently identify enrollees who might be ECM eligible for outreach.

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)

Being that AHF is an ECM provider, AHF sent a letter to LA Care, HealthNet and Molina in January 2022 offering to provide ECM services to its HIV-positive enrollees. Both HealthNet and LA Care responded and requested that AHF apply to be ECM provider. We did this and received a contract from HealthNet to take on ECM services for any of its enrollees that it would want to assign to us. HealthNet indicated it was unable to parse its census and assign us only HIV-positive enrollees. AHF offered to provide HealthNet with an algorithm to determine HIV status through encounter data. HealthNet declined and we deferred negotiations until such time they could assign us only HIV-positive ECM enrollees. LA Care deferred contracting with us till mid-2023. Molina declined contracting altogether. AHF will again contact HealthNet, Molina and LA Care to offer to provide ECM services for its HIV-positive enrollees who are using AHF Healthcare Centers. AHF Healthcare Centers are contracted with these MCPs.

In terms of leveraging WPC infrastructure, Los Angeles County Department of Health Services declined to contract with AHF to be an ECM or Community Supports provider. AHF ended up contracting with two of the housing navigation/tenancy service providers that DHS used in the WPC pilot. Note that 28 MCP enrollees received WPC services leading up to the ECM transition.

As part of the MCPs ECM team, the MPC hired one CHW working along side its RN Care Team Manger. Should ECM census grow, the MCP intends to hire additional CHWs to support ECM enrollees.

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)

The MCP collaborated with AHF's Healthy Housing Foundation to establish a fast-track referral and intake/application process for MCP enrollees who are homeless to apply for SRO housing at one of Healthy Housing Foundation's 12 low-income/homeless housing sites in Los Angeles County. AHF's Healthy Housing is an AHF division which continues to acquire former hotels and motels in underserved areas of LA County and converts them into housing units for low income/homeless individuals. It is also developing and building new low-income housing sites in LA County.

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)

As AHF is a DHCS-recognized ECM provider, it has solicited other MCPs as described in 2.1.17 to be their ECM provider. As noted, AHF will again offer by June 30, 2023 to take on ECM for LA Care, HealthNet and Molina enrollees who are HIV-positive and use AHF Healthcare Centers for primary care. We are open to taking on ECM services for these MCPs' HIV-positive enrollees, but not the general population.

AHF is submitting documentation related to its solicitation and application to be an HIV/AIDS ECM provider to the other County MCPs. This includes our individual letters to LA Care and HealthNet, our letter of interest to all MCPs in LA County, which includes plan partners, and our ECM provider certification submission to Health Net.

In June 2022, the MCP connected with the LAHSA, Long Beach COC and the HHIP Community Forum and introduced AHF's Healthy Housing Foundation to LAHSA as a resource for short- and long-term housing for the homeless and a model for building SRO unit capacity in the County in a separate meeting. AHF participates with the HHIP Community Forum.

AHF is submitting an email exchange introducing itself to the LA Care and HealthNet leads on the HHIP and LHP and the meeting details where the HHIP leads updated AHF on the County LHP and AHF introduced the leads to AHF's Healthy House Foundation.

Now that AHF's contract with DHCS to operate the MCP into 2023 is in place, AHF will resume working with the Community Forum to contribute and vet and share its approach to providing housing solutions to homeless Medi-Cal beneficiaries through AHF's Healthy Housing Foundation.

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. The MCP invested in its care management EHR to build out a module that tracks ECM RN and CHW activities by enrollee, by modality and function. This build out and reporting capability allows the MCP's Care Management leadership to provide oversight of ECM staff activities and performance. As noted earlier, to increase County ECM provider capacity, AHF will solicit other County MCPs, i.e., LA Care, HealthNet and Molina, to be an ECM provider to their eligible HIV-positive enrollees who use AHF Healthcare Centers for primary care. This is an innovative approach to offer ECM services to HIV-positive patients who already have a relationship with AHF.
    2. AHF trains its Care Management Department staff, which includes its ECM team, to document encounters with enrollees, create progress notes, updating care plan, etc. in its care management EHR. AHF provides all MCP staff with cultural competency training annually. AHF provides plan benefits training annual to Care Management staff.
    3. The MCP currently has adequate staff to provide ECM services to eligible enrollees who have consented to receive ECM. As census increases, the MCP will recruit additional CHWs and RNs to staff the ECM program.
    4. In terms of ECM training for AHF's Care Management Department, including the ECM team, the MCP's Plan Administrator, VP of Managed Care Operations (Clinical), National Director of Managed Care Operations and Associate Director of Care Coordination held training sessions for Care Management staff in November and December 2021. The training curriculum details ECM populations of focus, program structure, performance goals and outcomes, enrollee eligibility for ECM, how to utilize the MCP's care management module to document ECM encounters by enrollee, staff role, modality and function. The aforementioned leaders trained ECM staff members quarterly during 2022 as AHF executed contracts with Community Supports providers so ECM staff members learned about Community Support services and how to refer enrollees to Community Support providers. The MCPs

VP of Managed Care Operations (Clinical) and National Director of Care Coordination continue quarterly training of Care Management staff quarterly.

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.

The MCP operates in Los Angeles County, which does not have any DHCS-recognized IHCs. To date, no enrollees have requested access to or received services from an IHC or Tribal provider in an adjacent county which may have DHCS-recognized IHCs/Tribes. Should an enrollee request ECM services from an IHC or Tribal provider in an adjacent county in lieu of receiving ECM services from the MCP, the MCP shall contact the requested provider to establish either an MOU or LOA so that the enrollee may access the ECM provider. The MCP's ECM RN Care Team Manager will coordinate ECM services with the IHC/Tribal provider and the MCP's ECM team should the enrollee be eligible for 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)

Being that AHF is an ECM provider, AHF sent a letter to LA Care, HealthNet and Molina in January 2022 offering to provide ECM services to its HIV-positive enrollees. Both HealthNet and LA Care responded and requested that AHF apply to be ECM provider. We did this and received a contract from HealthNet to take on ECM services for any of its enrollees that it would want to assign to us. HealthNet indicated it was unable to parse its census and assign us only HIV-positive enrollees. AHF offered to provide HealthNet with an algorithm to determine HIV status through encounter data. HealthNet declined and we deferred negotiations until such time they could assign us only HIV-positive ECM enrollees. LA Care deferred contracting with us till mid-2023. Molina declined contracting altogether. AHF will again contact HealthNet, Molina and LA Care to offer to provide ECM services for its HIV-positive enrollees who are using AHF Healthcare Centers. AHF Healthcare Centers are contracted with these MCPs.

In terms of leveraging WPC capacity, AHF attempted to execute an MOU with Los Angeles County Department of Health Services (DHS). DHS declined. AHF did, however, contract with two of DHS's housing navigation tenancy sustaining service providers. The majority of the MCP's enrollees who received WPC services were assigned to housing navigation tenancy service providers. AHF did not need DHS for ECM services as it already had the care management infrastructure in place prior to CalAIM implementation.

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 MCP's queries its encounter data on a monthly basis to search for diagnosis code Z59.0 to identify enrollees who may be homeless. Because all enrollees in the MCP receive care management services based on severity level, in any instances where the care team discovers an enrollee may be homeless, the enrollee is passed to the ECM team for outreach to determine if he/she is homeless or at risk of being homeless. The MCP's RNs work with AHF Healthcare Center and network PCPs on developing and maintaining care plans and as a course of business remind the PCPs of the ECM benefit for homelessness or risk of becoming homeless. Again, if an RN learns that an enrollee might be homeless, he/she refers the enrollee to the ECM team for follow up.

[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.

The racial/ethnic group in the MCP census that has the highest incidence of homelessness or risk of being homeless is that of Black/African American followed by Hispanic/Latinx and White. Those enrollees who the MCP has determined may be homeless generally are suffering from mental health conditions and substance abuse in addition to having HIV. The MCP's approach to reach these racial/ethnic groups is the same. What differs is the one-to-one message, which MCP staff deliver in a culturally sensitive manner.

If the MCP's ECM team cannot reach the suspected homeless enrollee to verify homelessness and obtain consent for ECM over the phone, which is often the case, the enrollees assigned RN Care Team Manager or CHW will attempt to find the enrollee using any address information he/she can find though the PCP, specialists, pharmacy, and claims to make an in-person visit. The RN or CHW may also find out through the PCP's office when the enrollee has an appointment and meet the enrollee at the provider's office.

The MCPs Care Management team has encountered a few barriers to in reaching these populations. The first and biggest barrier is finding these enrollees when the MCP has no working phone number or the enrollee does not respond to the Care Management team's calls. The second is convincing enrollees to consent to receive ECM services. Some enrollees the MCP has encountered who are homeless do not want any intrusion by the MCP staff regardless if we explain the benefits of ECM. The third barrier is compliance with the care plan, which some enrollees do not want to follow and thus "disappear." To mitigate the first barrier, which can occur even after a homeless enrollee opts to consent to ECM, the MCP works County homeless shelter agencies to attempt to find enrollees when necessary.

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 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

[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.

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)

The MCP's Health Education Program and Member Engagement Manager will transition into the role of Health Equity Officer by July 1, 2023 (when she returns from maternity leave). This staff member possesses the necessary qualifications to transition to this new position.

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)

AHF did not vet its Gap-Filling Plan with other County stakeholders per se. Because AHF became a DHCS-approved ECM provider, it desired to collaborate with other MCPs in LA County to increase provider capacity by taking on ECM for other MCPs' HIV-positive enrollees. AHF sent a letter to LA Care, HealthNet and Molina in January 2022 offering to provide ECM services to its HIV-positive enrollees. Both HealthNet and LA Care responded and requested that AHF apply to be ECM

provider. We did this and received a contract from HealthNet to take on ECM services for any of its enrollees that it would want to assign to us. HealthNet indicated it was unable to parse its census and assign us only HIV-positive enrollees. AHF offered to provide HealthNet with an algorithm to determine HIV status through encounter data. HealthNet declined and we deferred negotiations until such time they could assign us only HIV-positive ECM enrollees. LA Care deferred contracting with us till mid-2023. Molina declined contracting altogether. AHF understands ECM provider capacity remains concern in LA County. AHF will again contact HealthNet, Molina and LA Care to offer to provide ECM services for its HIV-positive enrollees who are using AHF Healthcare Centers. AHF Healthcare Centers are contracted with these MCPs. We are also open to taking on ECM for these MCPs' enrollees provided they assign us HIV-positive patients.

AHF is submitting documentation related to its solicitation and application to be an HIV/AIDS ECM provider to the other County MCPs. This includes our individual letters to LA Care and HealthNet, our letter of interest to all MCPs in LA County, which includes plan partners, and our ECM provider certification submission to Health Net.

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.

Aetna has had all 14 Community supports Available at initial go live of 1/1/22 countywide. We supported our member plans in the county by participating in the Healthy San Diego Meetings to educate the public, provider trainings on CalAIM and Community Supports, leveraging our ECM providers to proactively identify members who could benefit from Community Supports and proactively identifying members through our internal interdisciplinary rounds. Aetna continues to evaluate CS needs on a monthly basis and has a list of additional potential providers that we are ready to contract with should we have additional needs that arise. As part of the CALAIM workgroups we are discussing ways that we can help increase additional provider capacity or setup new potential providers as a community supports provider in order to increase capacity. HSD for instance is discussing the need for an additional sobering center. Aetna has always offered all 14 community supports throughout the county from 1/1/22. Aetna constantly is looking at their providers and working with them to ensure increased reach, for instance we have one provider going to find the members, even if they may be homeless.

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. The MCP's Provider Relations and Utilization Management Departments collaborate to identify and resolve access challenges with respect to the MCP's Community Supports provider network. The MCP's current network of vendors providing housing tenancy and sustaining services, housing transition navigation services, meal delivery/medically tailored meals, and personal care and homemaker services currently meets the MCP's identified access and capacity requirements for enrollees. As enrollee utilization increases, the MCP's Provider Relations Department will continue to engage with existing Community Supports providers to confirm accessibility and availability and as need establish formal contract relationships with new Community Supports providers to meet enrollee needs.

2. With the exception of housing tenancy and sustaining services, house transition navigation services and environmental accessibility adaptations providers (EAA), AHF's Community Supports providers (for personal care and meals) have been providing services for and submitting claims to health plans, including Medi-Cal MCPs. AHF's personal care services and meal preparation/delivery providers did not need any technical assistance or training to render and bill for services. For the housing services providers, the MCP prepared a billing training guide for these providers to submit an invoice. In the case of the housing transition navigation services, the MCP's Plan Administrator and Associate Director of Data Analytics and EDI, provided TA multiple times to the provider in February 2023 to assist with submitting invoicing from which the MCP can pay. The MCP is working with a licensed contractor that AHF uses for its facilities to take on EAA for a July 1, 2023 go live. The contractor has never worked with any health plan in the delivery of EAA services. As part of our negotiations to contract with this contractor, the MCP has committed to train its billing staff on submitting invoices that the MCP can pay.

3. AHF has not taken any actions to support Community Supports workforce recruiting and hiring. The providers with whom AHF has contracted for Community Supports feel they can take on any MCP enrollees and render services using existing staff.

4. AHF provided orientation and training to its contracted Community Support providers as follows:

Community Supports Provider Name	Community Supports Services	Orientation Date	Orientation Location	Orientation Provider Attendees	Orientation PHC Attendees
The Catalyst Foundation	Housing Transition & Navigation Housing Tenancy & Sustaining	5/3/2022	Virtual	Joanna Ortega, Director of ICMS Perla Laborde, Lead Care Manager Dave Mashore, CEO Felicia Dennis, Program Manager Melissa Simmons, Director of Operations	Morgan Minson, UR Manager Courtney Mauger, Associate Director Provider Relations & Contracting
Volunteers of America Los Angeles	Housing Transition & Navigation Housing Tenancy & Sustaining	4/28/2022	Virtual	Mayra Garcia, Senior Program Manager Aimee Sherman, Program Manager Lidia Calleja, Program Coordinator Virgnia Adame, Program Director	Morgan Minson, UR Manager Courtney Mauger, Associate Director Provider Relations & Contracting Caitlin Tatum, RN Care Team Manager
Mom's Meals	Medically Supportive Meals Nutritional Counseling	6/27/2022	Virtual	Brianna Moncada, Manager of Healthcare Partnerships Susan Hildman, Implementation	Billy Alexander, Associate Director of Care Coordination Courtney Mauger, Associate Director Provider Relations & Contracting

Envoy Health Care, Inc	Homemaker & Personal Care	1/25/2022	Virtual	Lody Sazkissian, CEO	Courtney Mauger, Associate Director Provider Relations & Contracting
The Wright Home Care, Inc	Homemaker & Personal Care	1/25/2022	Virtual	Jennie Rios, Staff Coordinator	Courtney Mauger, Associate Director Provider Relations & Contracting

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)

The MCP operates in Los Angeles County, which does not have any DHCS-recognized Tribes. To date, no enrollees have requested access to or received services from an IHC or Tribal provider in an adjacent county which may have DHCS-recognized IHCs. Should an enrollee require or request Community Support services from a Tribal provider in adjacent

county in lieu of using MCP contracted providers, the MCP shall contact the requested provider and work to establish a LOA so that the enrollee may access the tribal provider. The MCP's ECM RN Care Team Manager will coordinate Community Support services with the Tribal provider should the enrollee require such Community Support 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)

During the implementation CalAIM and ILOS, the MCP attempted to work with Los Angeles County Department of Health Services, which ran the WPC program in the County. It declined to contract or execute an MOU with us. For the Community Supports that the MCP committed to provide and DHCS approved, the MCP found and contracted with an adequate number of vendors to serve the MCPs census of enrollees who may require Community Supports services.

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)

Because of the MCPs small census (<850) and even smaller number of enrollees who will be require and be approved to receive Community Support services (<100), AHF shared its Gap-Filling Plan with two former WPC CBO providers of housing services who provided services to the MCPs enrollees through WPC. AHF executed contracts with these providers and ensured they have capacity to take on our expected utilization, which is not significant in volume.

AHF is submitting copies of its contracts with Volunteers of America and The Catalyst Foundation along with documentation of our meetings with these providers.

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)*

AIDS Healthcare Foundation was approved by DHCS prior to the rollout of the ECM/ILOS programs to be its ECM provider for its enrollees. Because the MCP is an AIDS-specialty Medi-Cal plan, the MCP, since inception, has provided care management services to all of its enrollees. The amount and frequency of care management services is based on enrollee severity level determined through recurring health assessments in collaboration with the enrollee's PCP.

At this time, the MCP's Care Management staff are able to provide necessary ECM services to enrollees who have consented for such services and provide outreach to enrollees who the MCP has determined are eligible for ECM services.

The MCP has contracted with the Los Angeles Network for Enhanced Services (LANES) for HIE services. The MCP collects health information on its enrollees and stores this data in its care management medical record, called eQSuite.

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)*

AIDS Healthcare Foundation was approved by DHCS prior to the rollout of the ECM/ILOS programs to be its ECM provider for its enrollees. Because the MCP is an AIDS-specialty Medi-Cal plan, the MCP, since inception, has provided care management services to all of its enrollees. The amount and frequency of care management services is based on enrollee severity level determined through recurring health assessments in collaboration with the enrollee's PCP.

At this time, the MCP's Care Management staff are able to provide necessary ECM services to enrollees who have consented for such services and provide outreach to enrollees who the MCP has determined are eligible for ECM services.

The MCP invested in a care management medical record system, called eQSuite, prior to CalAIM. This system generates and manages individual enrollee care plans.

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)*

AIDS Healthcare Foundation was approved by DHCS prior to the rollout of the ECM/ILOS programs to be its ECM provider for its enrollees. Because the MCP is an AIDS-specialty Medi-Cal plan, the MCP, since inception, has provided care management services to all of its enrollees. The amount and frequency of care management services is based on enrollee severity level determined through recurring health assessments in collaboration with the enrollee's PCP.

At this time, the MCP's Care Management staff are able to provide necessary ECM services to enrollees who have consented for such services and provide outreach to enrollees who the MCP has determined are eligible for ECM services.

The MCP invested in a care management medical record system, called eQSuite, prior to CalAIM. To accommodate the need for tracking of ECM services and creating encounters for ECM services, the MCP invested in building out an ECM module within eQSuite. The MCP is able to log ECM RN Care Team Manager and Community Health Worker encounters with ECM enrollees and eligible ECM enrollees. The MCP converts the data the system captures, i.e., enrollee details,

activity (HCPCS), units of time spent providing service, and who provided service (RN vs. CHW), into encounter data that the MCP submits to DHCS.

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