# 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** | CalViva Health |
| **MCP County** | Madera |
| **Is County a Former Whole Person Care (WPC) Pilots or Health Homes Program (HHP) County?** | No |
| **Program Year (PY) / Calendar Year (CY)** | Program Year 1 / Calendar Year 2022<br>Payment 2 (Submission 2-A and Submission 2-B) |
| **Reporting Periods** | Submission 2-A: January 1, 2022 – June 30, 2022<br>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 Sytem Infrastructu** | Up to **200** points | *None* | *300 points* |
| **2. Enhancedare ManagemenCM) Provider Capcity Building** | Up to **170** points | Up to **30** points | *0 points* |
| **3. Communiy Supports Prvider Capacity Bug and Communityupports Take-Up** | Up to **250** points | Up to **50** points | *0 points* |
| ***Category Tls*** | 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)

CalViva Health has made progress on our January 2022 Gap-Filling Plan submission by: 1) conducting an assessment related to our contracted ECM providers' bi-directional access to HIE; 2) we have provided all of our contracted ECM providers with access to findhelp.com (accessible on our public website at: https://communitysupportsecm.findhelp.com/) and are making progress towards connecting with local CIEs/SHIEs where they exist; 3) making progress on development of the capability for ECM providers to utilize our Provider Portal to develop an electronic care plan that they can access and share with their team members to be deployed in Q4 2022; 4) conducting a feasibility assessment to become a CES access point, connect with local HMIS. In addition, CalViva Health collaborated with our Plan partner in Madera County to: 1) collect baseline data through an ECM certification application and gap closure process, 2) assess findings with our Plan partner, and 3) develop an IPP Grant Application process for contracted ECM providers to support their ability to

electronically store, manage, and exchange care plan information and clinical documents with other care team members; 4) provided joint trainings for providers to learn how to access IPP funding.

## 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)

CalViva Health is making progress on development of the capability for ECM providers to utilize our Provider Portal to develop an electronic care plan that they can utilize to document their member-specific goals and interventions to be deployed in Q4 2022. For care plans that have been developed and stored on the Provider portal, providers can edit the care plan. The care plan is accessible to other team members who have Provider Portal access. CalViva Health collaborated with our Plan partner in Madera County to: 1) collect baseline data through an ECM certification application and gap closure process; 2) assess finding with our Plan partner; 3) develop an IPP Grant Application process for contracted ECM providers to support their ability to access certified EHR technology or a care management documentation system able to generate and manage a patient care plan; 4) provided joint trainings for providers to learn how to access IPP funding.

## 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)

CalViva Health has increased Provider capabilities to submit claims or invoices by taking the following steps: 1) providing access to a claims processing service (Conduent) that accepts non-standard claims or invoices, accessible through our Provider Portal, 2) if a provider is electronically capable, they can submit a claim through an EDI transaction; 3) training providers on Conduent and making recordings publicly available on our website; and 4) equipping our field teams to support providers. By Q4, we will add help features to findhelp for our contracted CS providers to translate referrals to claims after receiving evidence of CS service.

In addition, CalViva Health collaborated with our Plan partner in Madera County to: 1) collect baseline data through an ECM/CS certification application and gap closure process, 2) assess findings with our plan partner, and 3) develop an IPP Grant Application process for contracted ECM/CS providers to support their ability to submit 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 an MCP with information necessary for the MCP to submit a compliant encounter to DHCS; 4) provided joint trainings for providers to learn how to access IPP funding.

### 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)

CalViva Health, identifies the top three underserved populations in Madera County to include the following ECM Populations of Focus: 1) Individuals and Families Experiencing Homelessness; 2) High Utilizer Adults; and 3) Adults with SMI/SUD.To determine ECM provider assignment for underserved populations, CalViva Health: 1) added SDoH data logic to our ECM provider assignment methodology to maximize the identification of impacted members and appropriately assign them in collaboration with our ECM-contracted County partners; 2) integrated this into our monthly ECM outreach files in March 2022; 3) we take into consideration the ECM Provider's Population of Focus (PoF) expertise to ensure the members are assigned to the most suitable provider; 4) we are conducting a feasibility assessment with the Fresno Madera Continuum of Care to understand current HMIS capabilities to better identify underserved populations. Our ECM assignments of ECM-eligible members will be matched on a monthly basis by ECM Population of Focus, capacity, and other indicators, which based on experience in our Phase 1 Counties we anticipate will lead to a consistent increase in ECM member engagement by the ECM providers from month-to-month.

## 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)

CalViva Health collaborated with our Plan partner in Madera County to: 1) convene the Central Valley CalAIM Roundtable to understand local level priorities, discuss best practices; and 2) collaborate on a joint IPP Grant Application process to support appropriate and sustainable ECM/CS infrastructure development and capacity-building. Barriers included: time constraints related to provider education, stakeholder capacity. Ongoing successful strategies include: utilizing a Steering Committee model; standing meetings with our Plan partner; supporting ECM/CS infrastructure development and capacity-building with IPP funding. The new CHW/Ps, who will reflect the population we serve, will support outreach, comprehensive assessment and care management planning, enhanced coordination and transitions of care, and referral coordination to community and support services.

## 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)

CalViva Health collaborated with our Plan partner in Madera County to: 1) convene the Central Valley CalAIM Roundtable to understand local level priorities, discuss best practices; and 2) collaborate on a joint IPP Grant Application process to support appropriate and sustainable ECM/CS infrastructure development and capacity-building. We are in continued discussions via the Central Valley CalAIM Roundtable to identify community priorities and solicit feedback to inform IPP community-wide investments to support the build of physical plants (e.g., sobering centers) or other infrastructure to support successful implementation of ECM/CS.

## 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)

CalViva Health collaborated with our Plan partner in Madera County to collect baseline data through the ECM/CS certification application and gap closure process. Plans will continue to leverage the Central Valley CalAIM Roundtable to understand local level, priorities, discuss with community partners the best ways to enhance and develop ECM/CS infrastructure, and to inform development of the Delivery System Infrastructure portion of our Gap-Filling plan. The Central Valley CalAIM Roundtable website contains access to all meeting materials (i.e., agendas, PPTs, list of organization types that are invited to attend, DHCS-approved IPP Needs Assessment and Gap Filling Plans) that document our collaboration. Additional supporting documentation is attached to demonstrate local level collaboration that informed the development of the Delivery System Infrastructure portion of the Gap-Filling Plan. We have publicly posted our IPP Needs Assessment and Gap-Filling Plans; in Q4 2022 (and thereafter), we will conduct a stakeholder survey to additionally inform ECM and CS delivery system infrastructure needs.

*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. CalViva Health has taken the following steps to increase ECM provider capacity and MCP oversight capacity: 1) engagement and contracting with a wide network of ECM providers that serve specific populations of focus; 2) monitoring of provider capacity via a monthly ECM provider performance scorecard for each contracted ECM provider; and 3) regularly requesting updated capacity information from ECM providers. In addition, CalViva Health collaborated with our Plan partner in Madera County to convene a transparent, local level CalAIM Roundtable to understand local level priorities and discuss with community partners the best ways to enhance and develop ECM provider capacity and MCP oversight capacity. We collaborated with our Plan partner on a joint IPP Grant Application process to support appropriate and sustainable ECM infrastructure development and capacity building.

2. CalViva Health has taken the following steps to address ECM workforce, training, TA needs, including specific cultural competency needs in Madera County by: 1) providing several training opportunities for ECM providers including, but not limited to: member engagement, claims and invoice guidance, and referral and authorization guidance: https://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/provider_engagement.html#calaim.html; 2) we have scheduled implicit bias trainings for our ECM providers in Q3 2022; and 3) we have developed cultural competency trainings that we will roll out to ECM providers in Q4 2022. In addition, CalViva Health collaborated with our Plan partner in Madera County to convene a transparent, local level CalAIM Roundtable to understand ECM workforce, training, TA needs in the county. We collaborated with our Plan partner on a joint IPP Grant Application process to support appropriate and sustainable ECM infrastructure development and capacity building.

3. CalViva Health has taken the following steps to support ECM workforce recruiting and hiring of necessary staff to build capacity: 1) executed an agreement with USC Keck to prepare a new or existing Street Medicine workforce to successfully deliver care directly to people experiencing unsheltered homelessness, and to advise programs on how to integrate street medicine into managed Medi-Cal and CalAIM; 2) developed a partnership with California Alliance of Child and Family Services to develop a network of ECM providers to serve Children and Youth Population of Focus through ECM capacity building and technical assistance; 3) we have signed an LOI with First 5 California to train CHWs as part of our larger

workforce development effort; 4) developed a broader workforce development strategy to address pipeline, training, certification and placement needs to scale existing programs and support our networks; 5) provided ongoing provider training on ECM. In addition, CalViva Health collaborated with our Plan partner in Madera County to convene a transparent, local level CalAIM Roundtable to understand ECM workforce, training, TA needs in the county. We collaborated with our Plan partner on a joint IPP Grant Application process to support appropriate and sustainable ECM infrastructure development and capacity building.

4. CalViva Health has developed a CalAIM training and TA program that uses live and on-demand webinars on topics including authorizations, referrals, claims, eligibility, data sharing, member engagement, grievances and appeals, operations, Findhelp and more: https://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/provider_engagement.html#calaim.html. Collectively, we have had 458 webinar attendees participate in our ECM training opportunities and 199 people leverage our recordings. CalViva Health collaborated with our Plan partner in Madera County to convene a transparent, local level CalAIM Roundtable to jointly provide CalAIM trainings to the communities we serve. The Central Valley CalAIM Roundtable website contains access to all meeting materials (i.e., agendas, PPTs, list of organization types that are invited to attend, DHCS-approved IPP Needs Assessment and Gap Filling Plans) that document our collaboration. We collaborated with our Plan partner on a joint IPP Grant Application process to support appropriate and sustainable ECM infrastructure development and capacity building.

## 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).

1. CalViva Health collaborated with our Plan partner in Madera County to: 1) convene the Central Valley CalAIM Roundtable to understand local level priorities, discuss with community partners ways to enhance and develop ECM/CS infrastructure, and 2) develop a joint IPP Grant Application process to support appropriate and sustainable ECM/CS infrastructure development and capacity building. The Central Valley CalAIM Roundtable website contains access to all meeting materials (i.e., agendas, PPTs, list of organization types that are invited to attend, DHCS-approved IPP Needs Assessment and Gap Filling Plans) that document our collaboration. We are in continued discussions via the Central Valley CalAIM Roundtable to identify community priorities, solicit feedback to inform IPP community-wide investments to support successful implementation of ECM/CS, and have promoted and provided updates on PATH funding for providers to leverage.

2. To address health disparities outlined in our Payment 1 response and deepen our engagement through strategic partnerships, CalViva Health has taken the following steps:

1. Disparities obtaining care post-hospitalization for adults experiencing homelessness: To enable ECM providers to facilitate timely post discharge care, our processes and training on services and benefits for all Plan Concurrent Review Nurses and Discharge Navigators incorporate attention to SDOH, including adults experiencing homelessness. Our Discharge Navigators coordinate multimodal discharge intervention with ECM and Short-Term Post-Hospitalization Housing and Recuperative Care (Medical Respite). Our CS providers establish a cohesive transition plan to support the member's needs.

2. Underdiagnoses of adults with SUD: To ensure ECM providers screen and link members to appropriate care, for Q2, we recently developed a workflow to refer members into ECM/CS from the sobering centers. We provide oversight during

monthly meetings to ensure ECM providers are linking members with SUD to appropriate community supports, through review of their scorecards.

3. Adult high utilizers with:

a) Co-occurring chronic conditions: We partnered with ECM providers with Plan clinical pharmacists by bridging gaps to allow ECM providers to leverage Population Health and Clinical Operations (PHCO) Liaisons to co-manage members, allowing them to focus on medication management that supports the focus on condition management. We are creating future PHCO Liaisons position to coordinate supports with ECM, Plan, and CS to support the member where they are in their health care journey.

b) Serious chronic illness: To ensure ECM providers refer to our Palliative Care Program, we risk stratified members enrolled in ECM to identify members who may benefit from palliative care support. Discharge planning begins with initial notification and is updated with each review. We provided training for Concurrent Review nurses planning for transition to the most appropriate setting. The discharge planning process and interdisciplinary Clinical Rounds also identify adult high utilizers with serious chronic illness who may benefit from Palliative Care. In Q3, training for clinical staff will include correct leveling (e.g., sub-acute, recuperative, home). PHCO Liaison to attend integrated Care plan meetings.

c) Frequent ED visits: We have on-site Discharge Navigators, Member Connections to outreach to members identified through data analytics to have frequent ED visits to support members to establish relationships with their medical home. Monthly meetings support ECM providers' connectivity with community programs to support the member's care.

## 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.

Response to Question 1.a.b.: Federally recognized Tribes in Madera County include North Fork Rancheria and the Picayune Rancheria of Chukchansi Indians (Source: NCIDC). The tribal designations of the California Indians in Madera County are: Mono, Sierra Miwok, and Yokuts (Source: UC Berkeley). North Fork Indian Health Center, and Central Valley Indian Health Center and Native American Center are Tribal providers serving Madera members. We estimate there are 52 CVH members in Madera County who use Tribal services and may use ECM. We had CalAIM conversations with Central Valley Indian Health on 3/10/2022, 4/14/2022 and 5/2/2022, including discussing ECM and CS contracting opportunities, and to provide a platform to address questions related to CalAIM. Central Valley Indian Health has expressed interest in serving as an ECM and/or CS provider and discussions are ongoing. In Madera County we have CS contracts in place to provide the following Community Supports to members in the County who are receiving Tribal services: Meals/Medically Tailored Meals, Asthma Remediation, Environmental Accessibility Adaptations (Home Modifications).

To support our CS contracting efforts in Madera County, CalViva Health collaborated with our Plan partner in Madera County to: 1) convene the Central Valley CalAIM Roundtable to understand local level priorities, discuss with community partners ways to enhance and develop ECM infrastructure, and 2) develop a joint IPP Grant Application process to support appropriate and sustainable ECM infrastructure development and capacity building. The Central Valley CalAIM Roundtable

website contains access to all meeting materials (i.e., agendas, PPTs, list of organization types that are invited to attend (inclusive of Tribes and Tribal providers), DHCS-approved IPP Needs Assessment and Gap Filling Plans) that document our collaboration. To address stakeholder feedback provided to-date, by Q3 2022, CalViva Health will collaborate with the California Rural Indian Health Board, the California Consortium for Indian Health, and our Plan partner to launch a CalAIM Roundtable specific to Tribes and Tribal providers and explore additional IPP grant funding opportunities specific to Tribes and Tribal Providers.

## 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)

CalViva Health collaborated with our Plan partner in Madera County to: 1) convene the Central Valley CalAIM Roundtable to understand local level priorities, discuss best practices; and 2) collaborate on a joint IPP Grant Application process to support appropriate and sustainable ECM infrastructure development and capacity-building. Barriers included: time constraints related to provider education, stakeholder capacity. Ongoing successful strategies include: utilizing a Steering Committee model; standing meetings with our Plan partner; supporting ECM infrastructure development and capacity-building with IPP funding. The new CHW/Ps, who will reflect the population we serve, will support outreach, comprehensive assessment and care management planning, enhanced coordination and transitions of care, and referral coordination to community and support services.

## 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)

Madera County has identified the following racial and ethnic groups that disproportionately experience homelessness in the County: (1) Black/African American, (2) Hispanic, and (3) White. Based on data including unhoused population, proportion to total membership, admits, and emergency department data, CalViva Health found the same racial and ethnic groups that disproportionately experience homelessness in Madera 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.

Madera County has identified the following racial and ethnic groups that disproportionately experience homelessness in the County: (1) Black/African American, (2) Hispanic/Latinx, and (3) White. According to the County Local Homelessness Plans submitted to DHCS in June of 2022, Black/African Americans are 18% of the population experiencing homelessness and 3.06% of the general population. People who identify as Hispanic/Latinx are 52% of the population experiencing homelessness and 58.33% of the general population. People who identify as White are 59% of the population experiencing homelessness and 33.42% of the general population. Please note this demographic information is based on the 2020 Housing and Urban Development Point in Time Count for the Fresno Madera Continuum of Care (CoC). Because the CoC spans two counties, the data above represents aggregate data for both counties. Based on data including unhoused population, proportion to total membership, admits, emergency department data, CalViva Health found the same racial and ethnic groups that disproportionately experience homelessness in Madera County.

CalViva Health took the following steps 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:"

- We utilized our HEDIS Disparity Dashboard – an interactive web-based tool that allows users to segment and analyze final plan-level HEDIS rates on select priority measures – to geographically pinpoint populations who are disproportionately affected by homelessness and to target resources, accordingly. Users can view multiple segments of the population, such as REL, geographic location, SDOH factors, and more. Rates can be compared against to establish national benchmarks and 95% confidence intervals are provided.

- We executed an agreement with USC Keck to support the development of a new workforce and to upskill the existing workforce in the region for 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.

- We leveraged our COVID-19 vaccine equity response work to lay the foundation for community relationships in the region that would allow us to deepen existing relationships and create new relationships to partners to decrease health disparities. Through building place-based equity interventions, many of which are focused on narrowing equity gaps for our Black members, we are poised to embark on the next phase of work: creating community impact councils in the region to partner with community-based organizations, leaders, and community members to co-create solutions for decreasing health disparities, particularly amongst populations that are experiencing homelessness.

- We partnered with our Plan partners to collaborate on a joint IPP Grant Application process to support appropriate and sustainable IPP funding to contracted ECM/CS providers, specifically soliciting providers with expertise serving this Population of Focus.

Barriers identified in reaching these populations include, but are not limited to, the following: medical mistrust and poor communication, staff bandwidth of ECM providers to conduct in person and multiple outreaches, and issues with data submission. Many providers are also unable to locate member contact information and/or have incorrect member contact information. Concrete steps taken/investments made to address these barriers are outlined above and are ongoing.

Related to partnerships with local partners, CalViva Health collaborated with the Fresno Madera CoC and our Plan partner in Madera County on strategies to address identified housing and service gaps in the County and to inform the Housing and Homelessness Incentive Program County LHP and Individual MCP LHP for Madera County. This included a comprehensive county analysis of needs and demographics, as well as an MCP analysis of member demographics, needs, and gaps. Identified barriers included in our MCP LHP related to: outreach and engagement efforts; availability of long-term affordable housing; accessible services and supports for individuals with SMI/SED. CalViva Health contracts with local ECM and CS providers support the expansion of culturally and linguistically sensitive networks for our members. We are partnering with the Fresno Madera CoC and our Plan partner to explore potential updates that can be made to the CES process, including how health factors and risks can be incorporated into the CES assessment and prioritization process.

## 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)

The top 3 racial and ethnic groups that experienced jail intakes in Madera County in 2021 were: White (21% of intakes; 87 intakes), Black/African American (7%; 30 intakes), and Hispanic/Latino (66%; 276 intakes). Note that not all intakes result in incarceration; these counts of intakes include individuals that were cited and released. Also note that some people have more than one jail intake, so this data does not represent a unique count of people. Data Source: Vera - https://trends.vera.org/state/CA

[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.

Building on CalViva Health's commitment to serve this population, CalViva Health assigned a dedicated health equity team to drive: 1) community partner engagement, 2) workforce development, 3) technical assistance, and 4) exchange of electronic clinical data to reduce barriers specific to outreach and engagement. We collaborated with our Plan partner in Madera County to: 1) convene the Central Valley CalAIM Roundtable to understand local level priorities, discuss best practices; and 2) collaborate on a joint IPP Grant Application process to support appropriate and sustainable ECM/CS infrastructure development and capacity-building to serve this vulnerable population. Identified barriers include, but are not limited to: 1) data exchange, 2) ensuring a seamless care coordination between the in-reach/pre-release period and the transition to ECM, 3) identification and engagement with culturally-responsive providers for our justice-involved population, and 4) "zero tolerance" policies that set a low standard to evict or reject participants from programs. In Q3 2022, we will finalize our strategy for targeted outreach and engagement to support this population. Our strategy will include associated interventions, such as: 1) investment in data sharing agreements and systems, 2) collaboration with justice-involved providers to coordinate between in-reach stage and transition to ECM, 3) collaboration with existing networks of ODR and other justice-servicing community and County partners to build capacity and infrastructure to serve this population in a culturally responsive way with IPP funding, and 4) de-escalation training to support providers in identifying processes that encourage mitigation, restorative justice, peer review processes. In Q4 2022, we will begin contracting efforts with ECM providers with justice-involved experience to better serve our members' needs with an equity and SDoH lens.

## 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)

## 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)

CalViva Health collaborated with our Plan partner in Madera County to collect baseline data through the ECM certification application and gap closure process. Plans will continue to leverage the Central Valley CalAIM Roundtable to understand local level, priorities, discuss with community partners the best ways to enhance and develop ECM infrastructure, and to inform development of the ECM Provider Capacity Building portion of the Gap Filling plan. Central Valley CalAIM Roundtable website contains access to all meeting materials (i.e., agendas, PPTs, list of organization types that are invited to attend, DHCS-approved IPP Needs Assessment and Gap Filling Plans) that document our collaboration. Additional supporting documentation is attached to demonstrate local level collaboration that informed the development of the ECM Provider Capacity Building portion of the Gap-Filling Plan. We have publicly posted our IPP Needs Assessment and Gap-Filling Plans; in Q4 2022 (and thereafter), we will conduct a stakeholder survey to additionally inform ECM delivery system infrastructure needs.

*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.

## 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. CalViva Health has taken the following steps to increase CS provider capacity and MCP oversight capacity: 1) engagement and contracting with a wide network of CS providers that serve specific populations of focus; 2) monitoring of provider capacity via a monthly CS provider performance scorecard for each contracted CS provider; and 3) regularly requesting updated capacity information from CS providers. In addition, CalViva Health collaborated with our Plan partner in Madera County to convene a transparent, local level CalAIM Roundtable to understand local level priorities and discuss with community partners the best ways to enhance and develop CS provider capacity and MCP oversight capacity. We collaborated with our Plan partner on a joint IPP Grant Application process to support appropriate and sustainable CS infrastructure development and capacity building.

2. CalViva Health has taken the following steps to address CS workforce, training, TA needs, including specific cultural competency needs in Madera County by: 1) providing several training opportunities for CS providers including, but not limited to: member engagement, claims and invoice guidance, and referral and authorization guidance: https://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/provider_engagement.html#calaim.html; 2) we will roll out implicit bias trainings in Q3 2022; and 3) we have developed cultural competency trainings that we will roll out to CS providers in Q4 2022. In addition, CalViva Health collaborated with our Plan partner in Madera County to convene a transparent, local level CalAIM Roundtable to understand CS workforce, training, TA needs in the county. We collaborated with our Plan partner on a joint IPP Grant Application process to support appropriate and sustainable CS infrastructure development and capacity building.

3. CalViva Health has taken the following steps to support CS workforce recruiting and hiring of necessary staff to build capacity: 1) executed an agreement with USC Keck to train new and upskill the existing Street Medicine workforce to successfully deliver care directly to people experiencing unsheltered homelessness, and to advise programs on how to integrate street medicine into managed Medi-Cal and CalAIM; 2) we have signed an LOI with First 5 California to train CHWs as part of our larger workforce development effort; 3) developed a broader workforce development strategy to address pipeline, training, certification and placement needs to scale existing programs and support our networks; 4) provided ongoing provider training on CS. In addition, CalViva Health collaborated with our Plan partner in Madera County to convene a transparent, local level CalAIM Roundtable to understand CS workforce, training, TA needs in the county. We collaborated with our Plan partner on a joint IPP Grant Application process to support appropriate and sustainable CS infrastructure development and capacity building.

4. CalViva Health has developed a CalAIM training and TA program that uses live and on-demand webinars on topics including authorizations, referrals, claims, eligibility, data sharing, member engagement, grievances and appeals, operations, Findhelp and more: https://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/provider_engagement.html#calaim.html. Collectively, we have had 227 webinar attendees participate in our CS training opportunities and 121 people leverage our recordings. CalViva Health collaborated with our Plan partner in Madera County to convene a transparent, local level CalAIM Roundtable to jointly provide CalAIM trainings to the communities we serve. The Central Valley CalAIM Roundtable website contains access to all meeting materials (i.e., agendas, PPTs, list of organization types that are invited to attend, DHCS-approved IPP Needs Assessment and Gap Filling Plans) that document

our collaboration. We collaborated with our Plan partner on a joint IPP Grant Application process to support appropriate and sustainable CS infrastructure development and capacity building.

## 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)

Response 1.a.b.: Federally recognized Tribes in Madera County include North Fork Rancheria and the Picayune Rancheria of Chukchansi Indians (Source: NCIDC).The tribal designations of the California Indians in Madera County are: Mono, Sierra Miwok, and Yokuts (Source: UC Berkeley).North Fork Indian Health Center, and Central Valley Indian Health Center and Native American Center are Tribal providers serving Madera members. We estimate there are 52 CVH members in Madera County who use Tribal services and may use ECM. In Madera County, we have CS contracts in place to provide the following Community Supports to members in the County who are receiving Tribal services: Meals/Medically Tailored Meals, Asthma Remediation, Environmental Accessibility Adaptations (Home Modifications).

To support our CS contracting efforts in the County, CalViva Health collaborated with our Plan partner in Madera County to: 1) convene the Central Valley CalAIM Roundtable to understand local level priorities, discuss with community partners ways to enhance and develop CS infrastructure, and 2) develop a joint IPP Grant Application process to support appropriate and sustainable CS infrastructure development and capacity building. The Central Valley CalAIM Roundtable contains access to all meeting materials (i.e., agendas, PPTs, list of organization types that are invited to attend (inclusive of Tribes and Tribal providers), DHCS-approved IPP Needs Assessment and Gap Filling Plans) that document our collaboration. To address stakeholder feedback provided to-date, by Q3 2022, CalViva Health will collaborate with the California Rural Indian Health Board, the California Consortium for Indian Health, and our Plan partner to launch a CalAIM Roundtable specific to Tribes and Tribal providers and explore additional IPP grant funding opportunities specific to Tribes and Tribal Providers.

## 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)

CalViva Health collaborated with our Plan partner in Madera County to: 1) convene the Central Valley CalAIM Roundtable to understand local level priorities, discuss best practices; and 2) collaborate on a joint IPP Grant Application process to support appropriate and sustainable CS infrastructure development and capacity-building. Barriers included: time constraints related to provider education, stakeholder capacity. Ongoing successful strategies include: utilizing a Steering

Committee model; standing meetings with our Plan partner; supporting CS infrastructure development and capacity-building with IPP funding. The new CHW/Ps, who will reflect the population we serve, will support outreach, comprehensive assessment and care management planning, enhanced coordination and transitions of care, and referral coordination to community and support 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)

CalViva Health collaborated with our Plan partner in Madera County to collect baseline data through the CS certification application and gap closure process and to jointly assess findings. Plans will continue to leverage the Central Valley CalAIM Roundtable to understand local level, priorities, discuss with community partners the best ways to enhance and develop CS infrastructure, and to inform development of the Community Supports Provider Capacity Building and Community Supports Take-Up portion of the Gap Filling plan. The Central Valley CalAIM Roundtable website contains access to all meeting materials (i.e., agendas, PPTs, list of organization types that are invited to attend, DHCS-approved IPP Needs Assessment and Gap Filling Plans) that document our collaboration. Additional supporting documentation is attached to demonstrate local level collaboration that informed the development of the Community Supports Provider Capacity Building and Community Supports Take-Up portion of the Gap-Filling Plan. We have publicly posted our IPP

Needs Assessment and Gap-Filling Plans; in Q4 2022 (and thereafter), we will conduct a stakeholder survey to additionally inform CS delivery system infrastructure needs.

*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)*

## 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)*

Outlined below are the concrete steps taken and investments that CalViva Health has made to increase the number of contracted Enhanced Care Management (ECM) providers in Madera County that engage in bi-directional Health Information Exchange (HIE).

Assessment of ECM Provider Capability to Engage in Bi-Directional Access to HIE

CalViva Health assessed all contracted ECM providers related to their capabilities to engage in bi-directional HIE. In addition, we collaborated with our Plan partner – Anthem Blue Cross – in Madera County to collect baseline data through an ECM certification application and gap closure process and collectively reviewed and assessed findings to determine the best approach to jointly address identified gaps.

Steps CalViva Health Has Taken to Ensure ECM Providers Have the Ability to Engage in Bi-Directional HIE

CalViva Health has made the following Plan-level investments to engage in bidirectional data exchange so we are able to access relevant and timely member data to support care coordination and ECM:

Health Net – on behalf of CalViva Health – plays a strong leadership role in the California HIE industry, promoting and exchanging HIE for the care of our members.

Health Net – on behalf of CalViva Health – participated in the CA State AB 133 Data Exchange Framework – an effort to connect all providers, hospitals, and clients to HIE and exchange data – and is a committee member on the Data Sharing Agreement and Policies & Procedures Subcommittee.

Health Net – on behalf of CalViva Health – has four FTEs dedicated to advancing this important work, including working with data exchanges to receive inbound facility ADT (Admission, Discharge, Transfer) notifications and electronic medical

record files in support of our members' health care, supporting HIE connections and data exchange and provision of data to ECM providers.

CalViva Health signed the CalHHS Data Exchange Framework (DxF) Data Sharing Agreement (DSA) on January 3, 2023.

We have the ability to send data in accordance with the Office of the National Coordinator for Health IT (ONC) interoperability rules and we also send certain data to HIEs and electronic medical records (EMRs) to retrieve clinical data and also close gaps in care. We also have the ability to connect to and ingest data from multiple sources, including Electronic Data Interchange (EDI) and Health Level Seven (HL7) for ADTs and Electronic Health Records (EHRs) from various HIEs and EMRs.

We are actively engaged with Madera County to explore bi-directional exchange of behavioral health data per the Behavioral Health Quality Improvement Program (BHQIP).

Our current roadmap also includes integration with Clinical Data (CCDAs) from a prioritized list of California health systems.

CalViva Health continues its work in connecting to HIEs across the region we serve. We are currently connected to the following HIE in Madera County and continue to assess our opportunities to connect to other networks: Manifest MedEx. We also provide ADT reports to eight ECM providers in Madera County through a Secure File Transfer Protocol (SFTP) process and will continue to encourage additional and/or net-new ECM providers to receive and utilize these reports to better coordinate care for our members. In addition, the Cozeva Provider Practice Enablement Tool, a cloud-based platform, is available to our providers to bridge the data between providers and the Plan to support our members.

MCP Collaboration to Address Identified Gaps

We collaborated with Anthem Blue Cross on a joint IPP Grant Application process to support contracted ECM providers' ability to engage in bi-directional HIE. We also partnered with Anthem Blue Cross to jointly fund a transparent, local level Central Valley CalAIM Roundtable to jointly provide CalAIM trainings to contracted ECM providers in Madera County on how to access IPP funding to address this gap, if identified. The Central Valley CalAIM Roundtable website contains access

to all meeting materials (i.e., agendas, PowerPoint presentations, list of organization types that are invited to attend, DHCS-approved IPP Needs Assessment and Gap Filling Plans) that document our collaboration. Additional trainings on how to access IPP funding were provided outside of the CalAIM Roundtable process as well.

As a result of this process, during the IPP Measurement Period of July 1 – December 31, 2022, CalViva Health awarded five providers in Madera County approximately $10,139.00 to increase the number of contracted ECM providers that engage in bi-directional HIE. Examples of what the funding supports includes, but is not limited to, the following:

Support the identification of health information exchange data sharing requirements, update, and testing of Middleware systems.

Fund HIE software and vendor solutions, execute HIE contract, staff training, develop policy and procedures, beta testing, full implementation

Support consulting services to build report integrations and design for MIFs / TELs, RTFs, OTFs, general reports, including the mapping, testing, and implementation process

Integration into existing platform, testing, import of new TEL / MIF, import of existing records

Going Forward

CalViva Health is committed to ensuring 100 percent of our contracted ECM providers have signed the statewide CalHHS DSA and engage in bi-directional HIE.

## 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)*

## 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*