CALAIM INCENTIVE PAYMENT PROGRAM (IPP)

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

Contents

Cover Sheet

Response Required to this Section

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

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

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

1. Details of Progress Report	
MCP Name	Anthem
MCP County	Nevada
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 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*	60
2. Enhanced Care Management (ECM) Provider Capacity Building	Up to **170** points	Up to **30** points	120
3. Community Supports Provider Capacity Building and Community Supports Take-Up	Up to **250** points	Up to **50** points	120
Category Totals	Up to **620** points	Up to **80** points	Up to **300** points
TOTAL	Up to **1,000** points		

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

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

End of Section

Instructions

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

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

Progress Report Format

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

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

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

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

Narrative Responses

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

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

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

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

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

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

Quantitative Responses

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

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

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

End of Section

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

Response Required to This Section

2.1.1 Measure Description

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

Quantitative Response

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

Enter response in the Excel template.

Narrative Response

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

Anthem collaborated with our Plan partners in Nevada County to: 1) collect baseline data through ECM/CS certification application/gap closure process, and 2) develop an IPP Grant Application process for contracted ECM/CS providers to support their ability to electronically store, manage, and exchange care plan information and clinical documents with other care team members.

Additionally, Anthem:

- Facilitated two provider webinars promoting IPP funding priorities, including IT upgrades for HIE connectivity.

- Provided two trainings and semi-weekly office hours with providers on utilizing Anthem's Provider Portal to electronically store, manage, exchange care plan information.
- Anticipates awarding $713,473 in IPP funding for IT system upgrades to support bi-directional exchange, including funding in Nevada for EA Family Services and Hospitality House.

2.1.2 Measure Description

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

Quantitative Response

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

Enter response in the Excel template.

Narrative Response

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

Anthem collaborated with our Plan partners in Nevada County to: 1) collect baseline data through ECM/CS certification application/gap closure process, and 2) develop an IPP Grant Application process for contracted ECM/CS providers to support their ability to access certified EHR technology or a care management documentation system able to generate/manage a care plan.

Additionally, Anthem:

- Facilitated two webinars promoting IPP funding priorities, including IT system upgrades for EHR
- Hosted two webinars and individually engaged providers in best practice discussion about EHR.
- Anticipates awarding funding for IT system upgrades to support EHR development in Nevada for Hospitality House, EA Family Services and Home and Healthcare Management.

2.1.3 Measure Description

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

Quantitative Response

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

Enter response in the Excel template.

Narrative Response

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

Anthem collaborated with our Plan partners in Nevada County to: 1) collect baseline data through ECM/CS certification application/gap closure process, and 2) 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.

Additionally, Anthem:

- Collected data through the certification application and gap closure process on invoicing capabilities of ECM providers.
- Facilitated two provider webinars promoting IPP funding, including IT upgrades for invoicing systems.
- Provided two trainings, semi-weekly office hours, and claiming guide on Anthem's Provider Portal.
- Hired dedicated associates to resolve provider claims/billing issues.
- Anticipates awarding $288,038 in IPP funding for IT system upgrades to support invoicing, including $24,199 in Nevada.

2.1.4 Measure Description

Mandatory
20 Points

Quantitative Response Only

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

Enter response in the Excel template.

2.1.5 Measure Description

Mandatory
20 Points

Quantitative Response Only

Number and percentage point increase in behavioral health providers with contracts in place to provide ECM that engage in bi-directional Health Information Exchange (HIE).

Enter response in the Excel template.

2.1.6 Measure Description

Mandatory
10 Points

Narrative Response Only

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

Anthem's Progress against the gap filling plan is:

- Identification of underserved populations in the county: We have chosen to utilize the following publicly available data sources to help in the identification of underserved populations: Center for Health Policy Research (CHIS), The Homeless Data Integration System, DHCS 2020 Health Disparities Report, Nevada 2019 Community Health Needs Assessment and Nevada County Community Health Improvement Plan. Discussions about underserved populations internally and externally with other MCP's and county partners has occurred. . Examples of populations discussed include Medicaid eligible individuals needing mental health and Substance Use Disorder services, facing access to care issues, and populations needing SDOH support like housing. Anthem's Health Equity Director mined internal member data sources with respect to diagnoses related to maternity, SUD, Asthma, Diabetes, High Blood Pressure, Cardiovascular disease, and Mental Health data. The analysis concluded AI/AN SUD (statistically significant), AI/AN cardiovascular disease (statistically significant), and B/AA Hypertension are the top 3 underserved populations in the county.
- Mining internal data methodology supports the publicly available data and has been developed through (1) a multi-source proprietary algorithm to identify ECM eligible members and place them in a Population of Focus that best aligns with their need. (2) ECM and CS provider referrals, member self-referrals, and other community referrals.

- Members are strategically assigned to ECM providers to support engagement with underserved populations by considering members' specific Population of Focus needs, previous provider relationships and member preference, geographic location, provider capacity, and cultural relevance of the provider to the member. To see the Providers Anthem members will be assigned to, Please see the attachment "Anthem MOC Phase III ECM Provider Capacity 092022" Anthem has prioritized engagement with local providers who best represent their communities and have established trust with underserved populations.
- Nearly 60% of awarded IPP funds were granted to organizations operating in a single county or region.

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)

- In collaboration with our Plan partners, Anthem enhanced and developed needed ECM and CS infrastructure by: 1) convening a CalAIM Roundtable to understand local level priorities, discuss best practices; and 2) collaborating on a joint IPP Grant Application process to support ECM/CS infrastructure development and capacity-building. As a result, 7 providers applied for IPP funding to expand IT infrastructure and add additional staff in the county.
- Anthem identified ECM capacity barriers to include time constraints related to provider education and outreach about CalAIM, misinformation about CalAIM FQHC funding processes, impacts from staffing shortages in general and became worse by Covid-19 pandemic.
- Ongoing successful strategies to address the barriers include:

    - Frequent targeted outreach to local providers,
    - Leveraging developed partnerships with other MCP's to collaborate on a streamlined IPP application process to minimize provider burden.
    - Utilizing a Steering Committee model with County Account Management to ensure CalAIM is a topic of discussion within the county,
    - Standing meetings with Plan partners to strategize roundtable agendas to ensure focused capacity expansion discussion continues and provider engagement does not decrease.
    - Supporting ECM/CS infrastructure development and capacity-building with IPP funding by approving requests from Nevada County, EA Family Services and Hospitality House to build or expand the current IT infrastructure at their organization and add staff.
- Successful roundtable outcomes include:
    - Discussing best practices for successful collaboration for IT infrastructure building
    - Across the 6 Counties included in the Gold Country roundtable which includes Nevada, there were 18 requests for IT infrastructure IPP funding support.
    - 4 providers applied for IPP funding in Nevada to expand IT and CalAIM capacity in the county via the roundtables process and MCO's jointly funded 3 of those providers.
    - For this reporting period, successful impacts from the approved requests will not be seen due to the timing of the application process, majority of milestone ending dates are after the reporting period, and the timing of funding rollout.

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

2.1.8 Measure Description

Mandatory
10 Points

Narrative Response Only

Describe any progress to build physical plant (e.g., sobering centers) or other physical infrastructure to support the launch and continued growth of ECM and Community Supports benefits. This response should provide detail regarding how the MCP has contributed to this infrastructure building, including but not limited to: financial contributions, participation in planning committees, partnerships with other MCPs and other community entities engaged in infrastructure building, etc. Please exclude technology-related infrastructure (e.g., IT systems) from this response. (100 word limit)

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

Additionally, Anthem:

- Implemented a process to prioritize proactive capacity building efforts with a focus on physical infrastructure needs. For prioritized service gaps, Anthem is deploying development resources to identify and engage provider partners, understand needs, and designate IPP funds to invest in start-up costs.
- Anticipates awarding $262,485 in IPP funding for physical infrastructure, including $63,099 in Nevada.

2.1.9 Measure Description

Mandatory
10 Points

Narrative Response & Materials Submission

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

AND

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

Anthem vetted components of our gap filling plan to counties via email and iterated the plan during the monthly CalAIM Nevada County MCP's Meeting. Attendees of the monthly meeting include Anthem Regional Program Manager, Anthem County Account Management Team, Plan partners and County Partners in Nevada County from Behavioral Health, Quality and HHS. Discussion includes the review of DHCS ECM and CS IT Infrastructure requirements as noted in DHCS Policy Guides, Plan specific provider guides and input into the ECM IT infrastructure requirements within the certification application for High Utilizers, SMI/SUD and Homeless PoF.

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

- Monthly Provider meetings with Anthems clinical team to encourage utilization.
- Anthems monthly Provider webinar series.
- The cross-county collaboratives where we share best practices to Providers.

- A webinar educating Providers about the Value Based Payment Program which includes an encounter and claims metric.
- The certification application and gap closure process reviewing and ensuring the importance of bi-directional data exchange.

Anthem collaborated with our Plan partners in Nevada to collect baseline data through the ECM/CS certification application and gap closure process. Plans will continue to leverage the 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 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 and a mechanism to receive feedback.

Anthem will continue to expand our vetting and stakeholder process which includes Soliciting input on the plan through existing MCO/County meetings, community forums and channels, such as facilitated community roundtables.

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

Steps to address the barriers include:

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

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

2. Cultural Competency and TA needs were identified and shared with the county. Within this reporting period, Anthem's focus within the County was primarily centered on educating what ECM and CS are, identification of providers who can serve these populations, and provider readiness. Moving forward, Anthem will attempt to add capacity within the county agenda to focus on and address cultural competency needs along with recruitment and retention of staff with lived experience. Notably, to address Cultural Competency, Anthem:

- Proactively gives CalAIM providers access to the Elsevier training library which includes cultural competency topics within the scope of behavioral health, nursing, and care management.
- Engaged a consultant to support building a model of care for the jail reentry population,
- Clinical Team members assess contracted Providers LCM race and ethnicities to support a diverse ECM membership.

TA needs were identified through the roundtable and direct provider questions to the Health Plan. Questions asked directly to the Health Plan include how to use Anthem's Provider Portal, how to complete an ECM certification application, support through the gap closure process, and questions about the MIF.

To address this feedback Anthem:

- Updates ECM provider guides on DHCS and Anthem expectations and technical assistance guidance about ECM and notifies providers of these updates.
- Hosts webinars/cross county collaboratives/roundtables reinforcing information Providers are needing assistance with.
- Office hours are held bi-weekly to support questions related to Anthems Provider Platform.
- 3 dedicated associate positions have been approved to support ECM providers with encounters, claims, and billing education and issue resolution.

3. As a result of the first round of applications Anthem is awarding $912,565 in IPP funding for ECM provider training and technical assistance, including providers EA Family Services and Home & Health Care Management.

4. See attached.

2.2.6 Measure Description

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

Narrative Response & Materials Submission

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

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

AND

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

2.2.7 Measure Description

Mandatory
20 Points

Narrative Response & Materials Submission

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

1. Describe progress against the narrative plan submitted for Payment 1 regarding collaborative work with Tribes and Tribal providers used by members in the county to develop and support the provision of ECM services for members of Tribes in the county (*see narrative measure 1.2.7, sub-questions 2-3*). This response should include details on (1)

concrete actions taken and investments made to demonstrate progress, (2) what issues have been identified in meetings facilitated to date, and (3) upcoming plans for meetings and other activities:
   a. Working with Tribes and Tribal providers used by members in the county on provider capacity.
   b. Providing ECM services for members of Tribes in the county.

OR

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

AND

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

Anthem outreached to tribal providers and tribal organizations within our contracted counties to build upon existing relationships or form new ones that could potentially open doors to tribal providers and tribal organizations in this county. Anthem has been outreaching to and/or communicating with Chapa De, CRIHB, CCUIH, and MACT. By Q4, Anthem will collaborate with our Plan partners to launch an Indian Health CalAIM Roundtable and promote ECM, CS and additional IPP grant funding opportunities specific to Tribes and Tribal Providers.

1a. Additionally, Anthem where applicable: Strategically prioritized outreach and follow-up to Tribes and Tribal providers. COVID in-person meeting limitations presented a challenge in engagement with providers lead by Tribal organizations that prefer in-person communication. In Nevada County, there are the Nisenan and Southern Maidu Tribes.

1b: 0 (zero) native American or Alaska Native members have enrolled in ECM during the measurement period.

2.2.8 Measure Description

Mandatory
20 Points

Narrative Response Only

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

Anthem continues collaborative efforts with California Health & Wellness and county stakeholders through ECM capacity discussions at:

- Joint steering committees, stakeholder round tables, training, certification application, and gap closure discussions
- MCO/MCO/Provider meetings
- Sharing of contracted network provider lists between MCOs.
- Joint funding of IPP applications

- Barriers included the time needed to educate providers and stakeholder capacity.

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

2.2.9 Measure Description

Mandatory
20 Points

Quantitative Response

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

Enter response in the Excel template.

Narrative Response

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

In Nevada County, the top racial and ethnic groups disproportionately experiencing homelessness are Black/AA, AI/AN, and Hispanic/Latinx. Barriers to reaching these racial and ethnics groups are a lack of housing to coordinate short-term and long-term supportive housing services; missing data on members experiencing homelessness, lack of accessible services to homeless individuals, the community in general is not aware of CalAIM services and how to access them; and low utilization of Z codes make it challenging for MCO's to identify homeless members.

[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.

To reach these Homeless Populations Anthem:

- Is using demographic data, z-codes, and public data, including the CDC's Social Vulnerability Index, to support eligibility determination, and prioritize eligible members for ECM outreach.
- Developed a proactive algorithm that specifically identifies Black/African American as a risk factor for prioritization.
- Engaged HMIS across the state to improve homeless identification.
- Hired a housing strategy team to focus on collaborating with local Continuums of Care and addressing inequities. This team presented to Anthem's internal SDOH committee their research that shows 21% of homeless are black compared to 12% within the general population and displayed for 6 counties the percent of Anthem Members who are Black and homeless.
- Anthem's clinical team through the certification application process, ensures cultural competency training has been delivered.
- After the ECM PoF starts, Anthem monitors provider outreach and engagement on a monthly basis and pays Providers for improvement via the Value-Based Payment program.
- Special Programs staff members meet monthly with contracted providers and share best practices, when available. In the first round of applications, Anthem is awarding $1.6M in IPP funding for ECM provider staffing expansions, including Nevada County Behavioral Health, EA Family Services, and Home & Health Care Management.

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

[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.

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

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)

Anthem's vetting process of the gap filling plan included:

- Solicited input via email from County agencies.
- Data from engagement through the certification application, gap closure process and regular county planning meetings.

Anthem collaborated with Plan Partners to establish local stakeholder Roundtables. The 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.

Anthem will continue to expand our vetting and stakeholder process by soliciting input on the plan through existing community forums and channels.

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.

Anthem has completed an in-depth CS network gap analysis. Results showed the need for STPH and Sobering Center Providers.

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

- Holding three roundtables and two webinars to educate stakeholders about CalAIM, the 14 Community Supports, and IPP funding opportunities to support provider take up of gap CS.
- Engaging with contracted providers to expand their services to additional counties such as Adventist.
- Completing an in-depth CS network gap analysis and prioritizing the most challenging gaps.
- Deploying CalAIM Regional Program Mangers to explore alternative techniques to identify different providers to outreach and engage, and assist known and/or contracted local providers in taking up gap CS's
- In the process of developing a CS value-based program that can reward specific CS providers for improvement in key areas such as member engagement.
- Engaged Anthem's Govt Relations Dir of Community Outreach to connect with contacts at AAA's, ILC's, ADRC's and other stakeholders to create opportunities for Anthem to provide education about Community Supports, the various CS provider types and how to become a CS provider.
- Developing a CS provider guide to inform interested providers about the multiple CS offerings.

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

2. To Support Technical Assistance and Cultural Competency, Anthem has:

    - Anticipated awarding $246,342 in IPP funding for CS provider training and technical assistance, across all Anthem counties including local investments to Nevada County Behavioral Health and EA Family Service.
    - Continually update CS provider guides on expectations and technical assistance on being a CS provider.
    - Giving CS provider access to the Elsevier training library which includes behavioral health, nursing, and care management educational topics.
    - Hosted webinars/cross county collaboratives/roundtables

3. Anthem has:

    - Invested $818,911 in IPP funding for CS provider staffing expansions, including Nevada County Behavioral Health, EA Family Services, Hospitality House.
    - Hosted regular in-service meetings with state-wide providers where capacity is a regular agenda topic.

4. See attached.

2.3.5 Measure Description

Mandatory
35 Points

Narrative Response Only

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

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

OR

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

Anthem outreached to tribal providers and tribal organizations within our contracted counties to build upon existing relationships or form new ones that could potentially open doors to tribal providers and tribal organizations in this county. Anthem has been outreaching to and/or communicating with Chapa De, CRIHB, CCUIH, and MACT. In May 2022, an Anthem CalAIM dedicated associate presented on CalAIM in collaboration with the Anthem Quality Team to the MACT Health Board. By Q4, Anthem will collaborate with our Plan partners to launch an Indian Health CalAIM Roundtable and promote ECM, CS and promote additional IPP grant funding opportunities specific to Tribal organizations and Tribal Providers. Tribal partners who have attended the regional roundtables include representatives from the Chapa-De Indian Health Center.

1a. Additionally, Anthem where applicable:

- Prioritized outreach and follow-up to Tribal organizations and Tribal providers.

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

1b: 0 (zero) native American or Alaska Native members have enrolled in CS during the reporting period.

2.3.6 Measure Description

Mandatory
35 Points

Narrative Response Only

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

In collaboration with our Plan partners, Anthem has started to enhance and develop CS capacity by:

- Convening a CalAIM Roundtable to understand local level priorities, discuss best practices; and collaborating on a joint IPP Grant Application process to support CS expansion and take-up. As a result, 5 providers applied for IPP funding to expand CS Capacity and add additional staff in the county. Nevada County BH, Hospitality House and EA Family Services were awarded funding for CS.
- Convening a regular Steering Committee meeting where Nevada County identified Hospitality House as a potential partner for community supports.

Anthem identified CS capacity barriers to include time constraints related to provider education and outreach about CalAIM, misinformation about CalAIM FQHC funding processes, impacts from staffing shortages in general and became worse by Covid-19 pandemic.

Anthem will continue to engage in the following moving forward:

- Identify gaps in service.
- Assess the current network and identify appropriate providers who have similar area of expertise, capabilities and/or facilities, and diversity necessary to support other CS's. For example, approaching providers who currently offer Recuperative Care to expand to Short Term Post Hospitalization housing and/or Day Habilitation services.
- Approach currently contracted providers who might be interested in expanding to support CS services.
- IPP funding will be made available to qualified interested providers.
- Utilize consultants to support gap filling activities.
- Engage experienced contracted providers to educate other potential community providers about how to operationalize CS.

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

2.3.7 Measure Description

Mandatory
30 Points

Quantitative Response Only

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

Enter response in the Excel template.

2.3.8 Measure Description

Optional

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

Quantitative Response Only

Asthma Medication Ratio (AMR)

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

Enter response in the Excel template.

2.3.9 Measure Description

Optional

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

Quantitative Response Only

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

Enter response in the Excel template.

2.3.10 Measure Description

Optional

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

Quantitative Response Only

Controlling High Blood Pressure (CBP)

Percentage of beneficiaries who meet the criteria for the Population of Focus ("people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions")

18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mm Hg).

Enter response in the Excel template.

2.3.11 Measure Description

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

Quantitative Response Only

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

Enter response in the Excel template.

2.3.12 Measure Description

Mandatory
20 Points

Narrative Response & Materials Submission

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

AND

Describe how all MCPs in the county vetted and iterated the Gap-Filling Plan with local partners within the county. This response should include a list of organizations with which the MCP collaborated, completed activities, and methods of

engagement. If no meaningful engagement or vetting with local partners was completed, please explain why and describe upcoming plans for vetting and iteration, including a list of proposed organizations, proposed activities, methods of engagement, and a time frame for completing these activities. (100 word limit)

Anthem collaborated with our Plan partners in Nevada County to collect baseline data through the ECM/CS certification application and gap closure process. Plans will continue to leverage the CalAIM Roundtable to understand local-level, priorities, discuss with community partners the best ways to enhance and develop ECM/CS infrastructure, and inform the development of the Community Supports Provider Capacity Building and Community Supports Take-Up portion of the Gap Filling plan. The 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 and established a mechanism for feedback.

Anthem's vetting process included soliciting input via email from County agencies.

Anthem will continue to expand our vetting/stakeholder process by soliciting input on the plan through existing ECM/CS Workgroups and the Behavioral Health Joint Operating Committee meetings.

End of Section

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

Response Required to This Section

2B.1.1 Measure Description

10 Points

Quantitative Response

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

Enter response in the Excel template.

Narrative Response

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

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

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

- In all shared counties, Anthem collaborated with California Health and Wellness / HealthNet to conduct a baseline assessment of current providers' access to and use of certified HIE technology, including perceived barriers and needs. Through this assessment, we found that most providers are not connected to a certified HIE system. The primary reason for this was that providers did not understand the value of using a certified HIE platform over their current mechanisms for bi-directional data exchange.
- Providers were able to apply for IPP funding to support development of/access to certified HIE technology.
- By June 2023, Anthem's goal is to:
  - Use PATH Collaboratives to discuss providers data exchange needs/priorities and assess how certified HIE systems could be leveraged to meet those needs.
  - Release at least one provider newsletter and one webinar on the topics of certified HIE and the CALHHS Data Exchange Framework. The goals of these materials will be to improve provider awareness of certified HIE benefits and increase providers that sign the CALHHS Data Exchange Framework Data Sharing Agreement.

2B.1.2 Measure Description

20 Points

Quantitative Response

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

Enter response in the Excel template.

Narrative Response

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

As part of the application process, all prospective Anthem ECM providers receive individualized support from a dedicated Regional Program Manager (RPM). The provider's current use and needs related to their EHR/care management documentation system are discussed at length during this process. In the previous reporting period, providers that identified any needs related to their EHR/care management documentation system were directed to DHCS PATH CITED funding stream and Anthem's IPP application process, which had funding available to support these needs. In Nevada County, during the reporting period, Anthem funded AMI Housing, Nevada County Behavioral Health and MasterCare to enhance their EHR/care management documentation capabilities. With that support AMI Housing has secured a contract with Social Solutions/Apricot 360 and went live with implementation. Nevada County Behavioral Health obtained 5 HMIS licenses, selected a case management database, set up the program, service types, billing and codes in selected system. All program types and services, codes have been built into the HMIS System. MasterCare has used their funding to design a case management platform, transferred PHI, and completed staff training. They have also been able to launch an SFTP site, which allows for report building, improvements to reporting for OTF/RTF, can allow import of new TEL/MIF and import of existing records.

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

- Provided all prospective providers with a care plan template that captured all required care plan elements.
- Allowed for significant flexibility in the acceptable format for submitted care plans, allowing for required elements to be captured in a variety of ways (drop down, free text, etc.)
- Delivered live webinar training for all lead case managers on care plan development best practices, facilitated by nurses from Anthem's Clinical Care team. In the reporting period, 13 ECM Care team Members serving Nevada participated in this training.
- Maintained a backlog of educational webinars, open to all providers, including those on EHR use and care plan documentation. During this period five providers from Nevada County accessed webinars related to EHR use and care plan documentation: AMI Housing, Home & Health Care Management, Hospitality House, MasterCare, Nevada County.

- Provided monthly webinars and newsletters on various subjects, including EHR use and care plan documentation. During this period, relevant webinar and newsletter topics included transitions of care and engaging members with SMI, new care plan functionality in CareCentral, and Person-Centered Planning training opportunities.
- Began developing a Provider training program that adheres to additional requests to enhance knowledge and expertise in providing best level of care for our members. Identified needs were collected through surveys and ongoing engagements with providers.

By June 2023, Anthem's goal is to:

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

2B.1.3 Measure Description

20 Points

Quantitative Response

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

Enter response in the Excel template.

Narrative Response

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

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

- Gave all providers personalized access to one of four Provider Network Consultants (PNC), dedicated to CalAim providers, who provide technical assistance with a focus on claims & billing. PNCs have regular calls – sometimes weekly – with assigned providers.
- Maintained an internal, cross-functional Claims Workgroup where PNCs (and others) can surface, troubleshoot, and resolve provider claims or invoice issues. This group met bi-weekly throughout the reporting period.
- Anthem's platform was originally developed for use by smaller, community-based organization. Many of the system updates that Anthem has made during this process have been to support more claims and billing by larger providers.
- Instituted 22 claims or invoicing updates to CareCentral – at a direct cost of $1.2 M – to improve ease of use for ECM/CS providers. An example of an improvement made was creating a capability for providers to bulk upload member claims.
- Distributed a comprehensive CS/ECM provider guide, which is regularly updated, to all newly contracted CS/ECM providers. This guide covers the various uses of CareCentral, including claims and billing.
- Offered providers the option of developing an electronic billing interface, through which ECM/CS providers can bill Anthem via a direct feed from the provider EMR/EHR.
- Providers were able to utilize IPP funds to pay for electronic billing interface development or other upgrades to their claims and invoicing system, a total investment of $1,190,259. In Nevada County, Anthem funded Home and Healthcare Management to enhance their electronic billing capabilities. With that support Home and Health Care Management can successfully bill for services.
- Hosted twice a week technical office hour for providers that need additional assistance using CareCentral. From Nevada County providers that have participated in office hours include EA Family Services, Home & Health Care Management, Hospitality House, MasterCare.
- Maintained a backlog of educational webinars, open to all providers, including those on claims and invoicing. During this period 4 providers from Nevada County access webinars related to claims and invoicing.

By June 2023, Anthem's goal is to:

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

2B.1.4 Measure Description

20 Points

Quantitative Response Only

Number and percentage point increase in contracted Community Supports providers for those Community Supports offered by the MCP during the measurement period with access to closed-loop referral systems.

NOTE: Closed-loop referrals are defined as coordinating and referring the member to available community resources and following up to ensure services were rendered. A closed-loop referral system refers to a system or process which ensures the referring provider receives information that the Member was appropriate referred to, and received, services.

Enter response in the Excel template.

2B.2.1 Measure Description

10 Points

Quantitative Response Only

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

Total FTEs are defined as the sum of ECM care team members' working hours divided by their employer's full-time working hours (i.e. 40 hours per week); multiple part-time ECM care team members can equate to one (1) FTE.

Enter response in the Excel template.

2B.2.2 Measure Description

10 Points

Quantitative Response Only

Number of Members enrolled in ECM

Enter response in the Excel template.

2B.2.3 Measure Description

10 Points

Quantitative Response Only

Number of members who are Black/African American and other racial and ethnic groups who are disproportionately experiencing homelessness that are enrolled in ECM during the measurement period.

Enter response in the Excel template.

2B.3.1 Measure Description

10 Points

Quantitative Response Only

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

Enter response in the Excel template.

2B.3.2 Measure Description

10 Points

Quantitative Response Only

Number of contracted Community Supports providers.

Enter response in the Excel template.

End of Section

APPENDIX A: Definitions of Commonly Used Terms

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

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

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

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

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

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

End of Section

APPENDIX B: Quality Measure References

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

IPP Payment 2 Measure	Description		Specifications Reference[7]
	2.1.1	Number and percentage point increase in contracted ECM providers that engage in bi-directional Health Information Exchange (HIE)	*Please refer to Health Information Exchange (HIE) Bi-Directional Exchange definition in Appendix A*
	2.1.5	Number and percentage point increase in behavioral health providers with contracts in place to provide ECM that engage in bi-directional Health Information Exchange (HIE)	*Please refer to Health Information Exchange (HIE) Bi-Directional Exchange definition in Appendix A*
	2.2.13	Plan 30-Day Readmissions (PCR)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
	2.2.14	Ambulatory Care—Emergency Department Visits (AMB)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
	2.2.15	Depression Screening and Follow-Up for Adolescents and Adults (DSF)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans

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

2.2.16	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)	HEDIS® Measurement Volume 2 Technical Specifications for Health
2.2.17	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.2.18	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.2.19	Controlling High Blood Pressure (CBP)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.2.20	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.3.8	Asthma Medication Ratio (AMR)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.3.10	Controlling High Blood Pressure (CBP)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans
2.3.11	Comprehensive Diabetes Care (CDC)	HEDIS® Measurement Volume 2 Technical Specifications for Health Plans

End of Section