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	Contra Costa Health Plan
MCP County	Contra Costa County
Is County a Former Whole Person Care (WPC) Pilots or Health Homes Program (HHP) County?	WPC Only (no HHP)
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*	*300 points*
2. Enhanced Care Management (ECM) Provider Capacity Building	Up to **170** points	Up to **30** points	*0 points*
3. Community Supports Provider Capacity Building and Community Supports Take-Up	Up to **250** points	Up to **50** points	*0 points*
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)

CCHP has worked closely with our ECM providers (Contra Costa Public Health and Contra Costa Behavioral Health) to successfully roll out the Compass Rose ("CR") Platform in EPIC for our ECM providers. The providers were previously documenting in ccLink (EPIC). This includes customizing CR, a dedicated case management module, for ECM, training all staff on CR, and deploying CR for day-to-day operations. CR is integrated with EPIC and CareEverywhere. It is used to store, manage, and securely exchange health information and other clinical documents with care team members.

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)

Over the first three (3) months of ECM, CCHP worked closely with Contra Costa Health Services Division IT and both of our ECM providers to roll out Compass Rose, as described above. This was completed in Q1 of 2022 and at this point, all of CCHP's contracted ECM providers have access to Compass Rose, which is certified EHR technology that is able to generate and manage a patient care plan.

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)

CCHP's ECM providers (3/3) are able to submit a claim to CCHP through the work done with Contra Costa Health Services Division IT. CCHP's Community Supports Providers can either submit a claim to CCHP through the work done with Contra Costa Health Services Division IT (3/3) or through the CCHP Provider Portal (7/7). The Community Supports providers also have the capability and option of submitting an excel invoice to CCHP with the information necessary for CCHP to submit a complaint encounter to DHCS if the Community Supports providers choose not to use the CCHP Provider Portal to submit a claim.

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)

CCHP and Contra Costa Business Intelligence (BI) team collaborate to identify underserved members at-risk for poor health outcomes. This includes individuals experiencing homelessness, are justice involved, or are high utilizers. Regarding homelessness, BI gathers data from claims, medical records, and HMIS to identify individuals experiencing homelessness in the last 30 days. For justice involved, BI uses data from the detention health services to identify all CCHP members that have been booked into county jail in the last year. Regarding high utilizers, BI uses claims data and CCHP conducts manual review to identify and link them to ECM. SMI and SUD data are gathered from claims, the medical record, Specialty Mental Health, and Emergency Medical Services to identify individuals meeting criteria related to behavioral health hospitalizations, overdose, suicide, pregnancy/post-partum, and at risk of institutionalizations. Claims data related to 42CFR Part2 are being excluded.

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)

CCHP has worked closely with Anthem & Kaiser and defined the MOC requirements for working with Public Health to leverage existing capacity. CCHP has contracted 7 CS providers & the Homeless Program (H3) and Public Health who worked closely with the Community Supports providers to roll out the medically tailored meals and medically supportive foods benefit, including doing information sessions, technical assistance, and check-ins. CCHP has also hosted sessions to educate providers. We are adding CHWs to 14 existing FQHC contracts to interface with the eligible population. Barriers include acclamation of ECM providers to manage care & understanding outcome measures.

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)

CCHP conducts regular meetings with Contra Costa County Health Services Division Housing and Homelessness (H3), Behavioral Health, and Public Health in terms of discussing total respite capacity and post-hospital stabilization capacity and appropriate workflows. CCHP meets regularly with Contra Costa Behavioral Health Services, which is working on opening a sobering center in Contra Costa County. These items have also been discussed at both the CalAIM Steering Committee as well as the Contra Costa Health Services Division Leadership meeting.

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)

CCHP has been working closely with Contra Costa Public Health, Contra Costa Behavioral Health, and Contra Cost Health, Housing, and Homelessness through its CalAIM Steering Committee, Contra Costa Health Services Health Services Division, CalAIM Informatics Meetings, and additional CalAIM Meetings.

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. Provider capacity was increased through Compass Rose Implementation & regular meetings explaining program requirements. A new medical director was hired to oversee the program. Worked with the BI team to develop dashboards coming from earlier integrated data for program performance. Now working with providers to develop a set of outcome metrics and trying to implement to assist with oversight. Adding ECM to 4 FQHCs contracting will be completed this fall. Audits are performed to ensure compliance & emphasizing the medical model and looping in the PCP.
2. Significant training has occurred on technology integration with Compass Rose. CCHP's Quality and Provider Relations performed a training for the ECM Providers on C&L. Shared P&Ps with providers. At weekly staff meeting, the ECM leadership team updated. Learned from the experience of the COVID-19 outreach and leveraged that experience. Provider PH/BH are well engaged with the various ethnic communities. Therefore, from the COVID-19 experience we understand the communities that we serve who were at greatest risk and continues to be for ECM/CS services. Many staff of color were recruited and continue to be part of the PH ECM providers.
3. .We did an overview of the Community Health Work benefit and educated the Safety Net providers on the services and encouraged them to submit an amendment to their contracts. Also, we contracted with a CBO-Journey Healthcare that will be doing outreach services for Community Support with the CHW workers. Journey Healthcare has a team of CHW workers who we will connect with out ECM/CS providers to interface with the members face to face. Also, we are in negotiation with CHW Internship Program with Diablo Valley College.
4. Please see attachment E/G.

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. CCHP meets regularly with CCPH, CCHBH, CCHS H3, the Sheriff's Department, Probation, Employment Health Services Division (EHSD) to support PATH efforts. Successful submissions resulting from this effort include a PATH submission for the Justice Involved Population and a PATH submission for housing deposits through our WPC Providers. No formal MOU is in place because these are all different local government entities are operating under agreement and direction from the board of supervisors. CCHP has also communicated regularly with the federally qualified health centers about PATH as well as with our medically tailored meals and medically supportive meals community support providers.

2. The planning for the pre-release justice involved population, which inherently highlights disparities for populations of color, is ongoing. The Contra Costa County team has worked together to submit the PATH application for justice-involved. Additionally, the CCHSD BI team has pulled data discussing the potentially eligible population and is currently discussing Medi-cal enrollment, suspension, and reactivation workflows as well as pre-release inreach and assessment. This focus will ensure that the disparities represented by the justice-involved populations are addressed in a thoughtful way through a multi-agency strategic partnership.

Please see attachment F.

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.

CCHP has worked closely with the Health Services Division Chief Equity Officer and our cultural linguistic liaison to better understand the needs of our communities and members, including those who receive Tribal Services. The Chief Equity

Officer has done a number of community sessions and shares weekly updates with CCHP, PH and BH. Best practices include insights on community members receive Tribal services. This prepares CCHP to expand into Tribal Services if we have new Tribal membership in our county. Chief Equity Officer oversees the MOU training with the Justice Collective. Surveys completed to measure Equity temperature. Case managers in PH & BH are benefiting from cultural competence training.

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)

CCHP works closely with Anthem, Kaiser, and the County Whole Person Care Providers (Public Health) to leverage existing WPC capacity. CCHP is working with Anthem to develop additional ECM providers in the county, including the Federally Qualified Health Centers such as La Clinica, Brighter Beginnings, and Lifelong. Community health workers are an important part of the ECM teams, but now can also provide services to non-ECM recipients. As such, supporting expansion of this workforce will also expand the pool of individuals who can be hired to provide ECM 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)

CCHP identifies individuals experiencing homelessness by aggregating data. Identification barriers include the lack of reliable contact information, substance use disorder, insufficient affordable housing access, and complex behavioral health conditions. Furthermore, CCHP identifies individuals through inpatient admissions during its weekly hospital rounds. CCHP alerts ECM providers to these patients. CCHP has been partnering with the Contra Costa Health, Housing and Homelessness (H3) Division, their CORE Outreach Teams, 2-1-1, community organizations like Bay Area Community Services through working closely with H3 and the CoC. CCHP has also been partnering with all of the area hospitals including Sutter Delta, John Muir Walnut Creek and Concord, Kaiser Richmond, Kaiser Antioch, and Contra Costa Regional Medical Center. CCHP also facilitates meetings with the inpatient teams at major county hospitals, to facilitate communication with hospitalized patients and their inpatient teams. H3 supplied 22 new units of Permanent Supportive

[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.

Housing for chronically homeless high utilizers, met with three HN/housing deposit service providers to expand services, and is lobbying to receive funding for cell phones to be distributed by street outreach teams.

The specific barriers in the county include lack of reliable contact information, high rates of substance use disorder, and high rates of complex behavioral health conditions. Additional barriers include low health literacy and lack of investment in both East and West County, insufficient affordable/subsidized housing options, lack of housing deposits/housing navigation providers to support rapid exits from homelessness, maintaining communication with the unsheltered for follow up services and lack of shelter capacity to supports persons with pets.

CCHP has been reaching out to all groups experiencing homelessness, including individuals who are Black/African American who reside in East and West County. One strategy has been engaging with these groups as they cycle through both the inpatient and emergency department settings. A second has been through working with Contra Costa Health, Housing and Homelessness (H3) Division to ensure outreach to this population through teams that conduct street outreach and/or are points of entry into CES (e.g. CORE Team and 2-1-1). Additional steps taken to address the barriers include H3's awarded HUD funding for 22 new units of Permanent Supportive Housing for chronically homeless high utilizers of the health system; CCHP collaborating with H3 to identify HN/housing deposit service providers. CCHP met with three providers to identify partnerships that can support the expansion of services; H3 partnering with Aging and Adult Services and Public Health to receive state funding for cell phones that will be distributed by street outreach teams to increase communication with the homeless; H3 was awarded two Pet Assistance Support grants that will decrease barriers of entry for those with pets at two local shelters.

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)

CCHP works with BI to identify Black/African American individuals that experienced incarceration within the last 12 months and assign them an ECM provider. CCHP implemented a process where individuals released from detention are automatically approved and assigned to an ECM provider the following day. Additionally, CCHP is convening a CalAIM Justice Involved Steering committee composed of CCHP, Detention Health Services, Employment and Human Services, the Sherriff's department, and the ECM providers to identify barriers to accessing re-entry services and develop subsequent.

[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.

Working groups around Medi-Cal pre-release, behavioral health warm handoff, and ECM have been convening to create solutions and process improvements.

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)

NO - CCHP is part of Health Services Division (HSD) and a Chief Equity Officer was hired in March 2020. Our plan is to work with the Chief Equity Officer and hire a Director of Equity that will do the daily operations. Estimated hiring is Q2 of 2023. However, we have the working relationship at the division level. Due to CCHP being part of Contra Costa County, we

have to submit a P-300 which will be submitted in Q4 for the Equity Director who will report to the CEO and a dotted line to the HSD Chief Equity Officer.

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)

CCHP addresses ECM capacity building with existing ECM providers, CCPH and CCBH as well as our future partners, the Federally Qualified Health Centers. This is done through the CCHSD Leadership Meetings, the CalAIM Steering Committee Meeting, CCHP Monthly CMO meetings and relevant Joint Operations Meetings. The completed activities include review and discussion of expectations, ongoing needs, and strategies for how to identify and serve the additional populations of focus. Ongoing regular meetings are scheduled to continue to discuss how to expand ECM to serve the additional populations of focus eligible for ECM over the next year.

End of Section

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

Response Required to This Section

2.3.1 Measure Description

Mandatory
30 Points

Quantitative Response Only

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

Enter response in the Excel template.

2.3.2 Measure Description

Mandatory
30 Points

Quantitative Response Only

Number of contracted Community Supports providers.

Enter response in the Excel template.

2.3.3 Measure Description

Mandatory
35 Points

Narrative Response Only

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

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

1. CCHP has a robust network of 7 CS providers for Medically Supportive Foods and Medically Tailored Meals. This includes both national providers as well as local providers. CCHP has worked extensively with the local providers (Project Open Hand and 18 Reasons) who have needed more assistance to ensure that they are able to participate as equal partners in this CS. For the housing related CSs, CCHP has worked closely with PH, BHS, and H3 to understand current capacity and develop a plan for expanding this capacity through H3's existing partnerships with CBOs, the CoC, and the homeless system of care.

2. CCHP went from the 2 CS that were initially offered in Whole Person Care to a total of 7 by July 2022. This includes partnering with PH, BH, and H3 to add medical respite, post hospital stabilization housing, asthma home remediation, and housing deposits. CCHP has built a robust network for medically supportive foods and medically tailored meals. This was achieved through numerous meetings to discuss concept and execution as well as to provide technical assistance with system design, referral submission, receiving authorizations, invoice/encounter data submission, and the many other nuances of working with a managed care plan.

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. CCHP works closely with Contra Costa BHS, PH, and H3 to increase capacity and streamline workflows for post-hospital stabilization housing, respite, housing navigation and tenancy support community supports. The teams meet regularly through a variety of forums including, but not limited to the CalAIM Steering Committee, separate housing community supports workgroup meeting (now ended – during the startup period), and the CCHSD leadership meetings. For our CalAIM Medically Tailored Meals and Medically Supportive Foods, we meet regularly with the providers to explain the program, how to contract, how to use our provider portal to send/receive referrals, how to bill, etc.

2. The regular meetings that CCHP has hosted with all of the CS providers have been in part focused on TA around billing, data capture and sharing, referral process + ccLink/ccLink Provider Portal utilization, and communication with CCHP UM to ensure that the entire process of interfacing with managed care and working through the managed care framework has been successful. The concrete steps taken to address with Community Supports workforce, training, and includes specific cultural competency needs by region/county include working out workflows for referrals, data capture, and billing and specific training and technical assistance to the CS providers workforce on how to do this work. Additionally, there has been work on breaking down the barriers of how to communicate with the healthcare teams in both the inpatient and outpatient setting. These are the highest need identified by our CS partners because the H3 and partner staff are experts in the area of working with individuals experiencing homelessness. They wanted assistance in training their staff in interfacing with both the health plan as well as how to develop a closer relationship with healthcare provider partners whom they traditionally do not have as tight of a relationship with. Contra Costa County Health Services Division's Chief Equity Officer has taken on a number of community and staff listening sessions and is sharing the findings with both CCHP and its partners to see what cultural competency (outside of health systems cultural competency) would be beneficial for the teams.

3. In terms of Community Supports workforce and hiring, CCHP has worked closely with Contra Costa BHS, PH, and H3 through the Office of the Director and Health Services Personnel to understand the challenges, including challenges around hiring, the culture in HSD and equity (in partnership with the Justice Collaborative). The findings are being used by

Health Services Personnel to streamline hiring practices in order to assist with the hiring of Community Supports staff in BHS, PH, and H3.

4. Please see Attachments A/B/E.

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)

CCHP has worked closely with the Contra Costa Health Services Chief Equity Officer and our cultural linguistic liaison to better understand the needs of our communities and members, including those who receive Tribal Services. The Chief Equity Officer has done a number of community sessions around the County and shares weekly updates at Contra Costa Health Services Division's leadership meeting with CCHP, CCPH, and CCBHS where these lessons, including insights on community members who receive Tribal services, are then channeled into ensuring culturally competent community support services.

2.3.6 Measure Description

Mandatory
35 Points

Narrative Response Only

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

CCHP works closely with CCPH, the former WPC provider, as well as CCBH, H3, and medically tailored meals/medically supportive foods providers through regular meetings to discuss CS capacity and expansion, building off of existing WPC Capacity. CCHP has also met with Anthem and H3 to explore expanding capacity. Workflow and communication barriers were identified and addressed. Regular communication and iterative process improvement proved to be successful. CCHP plans to continue meeting regularly with its CS providers and Anthem to identify barriers and improve workflows. CHWs will be leveraged to increase the overall qualified workforce for these CS.

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)

CCHP met regularly with CCPH, CCBHS, CCH3 through HSD leadership and the CalAIM Steering Committee to develop the Community Supports Provider Capacity Building and Community Supports Take-Up portion of the Gap-Filling Plan. CCHP has also met regularly with H3 and the CoC. These conversations have focused both on understanding how CCHP can access and leverage existing capacity as well as how CCHP can work with these partners to increase overall capacity. CCHP has also met regularly with the Community Supports Medically Tailored Meals and Supportive Foods providers to understand their limitations, provide technical assistance, and think through growing capacity.

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)*

All three of CCHP's ECM providers (Contra Costa Public Health, Contra Costa Behavioral Health, and Kaiser Permanente) utilize Epic for their case management documentation. Epic's encounters for case management are part of Epic's Health Information Exchange, CareEverywhere, allowing care management notes to be shared across provider networks. The vast majority of CCHP network providers utilize Epic. All of the hospital systems in Contra Costa County utilize Epic, along with the FQHCs, public hospital and health centers, Kaiser Permanente, and a large number of practice groups within the CCHP network. In addition to case management notes being visible to the wider network, other elements are visible to provider networks such as the care team, so providers can see the direct contact information for the lead care manager. Being integrated into Epic's HIE CareEverywhere, care managers are able to see real-time admissions and discharges through ADT feeds.

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)*

CCHP has worked closely with our ECM providers (Contra Costa Public Health and Contra Costa Behavioral Health) to successfully roll out the Compass Rose Platform in Epic for our ECM providers. The transition to Epic's specialized case management platform has allowed for greater standardization and tools, especially as it relates to documenting closed loop referrals, as case managers have discrete tasks and an integration with Findhelp.org. CCHP has worked closely with the IT department with Public Health and Behavioral Health on specification requirements and assisting providers in extracting encounter data from their case management platform for billing purposes. During the measurement period, there was training for staff on the Epic's Compass Rose, as well as a new care manager dashboard that helps track key performance indicators for a person's individualized caseload. The third ECM provider, Kaiser Permanente, also utilized Epic for its case management documentation.

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)*

CCHP providers are able to submit claims to CCHP in multiple ways: 1) invoice template, where provider fill out an excel sheet and upload this on the provider portal; 2) by directly imputing services directly in the provider portal; and 3) For providers within Contra Costa Health Services, the IT department has created a process where services rendered in HMIS or Epic are able to be automatically extracted, put in invoicing format, and converted to an 837 claim. CCHP provided resources for infrastructure build of this automated process for the Coordinated Entry Homeless Department, Public Health, and Behavioral Health. CCHP has done trainings and troubleshooting with providers on submission processes, and has created a dashboard to monitor denied, pending, and rejected claims so that Community Supports and ECM providers can monitor submissions and resubmit services if needed.

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