California Department of Health Care Services
Submission Template for CalAIM Incentive Payments Measures
Payment 1: Gap-Filling Plan Measures
September 2021

Gap-Filling Plan and Narrative Measures for Payment 1

MCPs that operate in multiple counties will need to submit a separate Gap-Filling Plan for each county.

MCP Name	Contra Costa Health Plan
MCP County	Contra Costa
Program Year (PY) / Calendar Year (CY)	Program Year 1 / Calendar Year 2022

Note: See Excel Document for Accompanying Needs Assessment Template for Payment 1

Priority Area	Percentage of Points Allocated to Each Priority Area	Points Needed to Earn Maximum Payment 1	MCP Discretionary Allocation of Remaining 300 points *(MCP to enter point values in cells below)*
1. Delivery System Infrastructure	Minimum 20%	200	0
2. ECM Provider Capacity Building	Minimum of 20%	200	0
3. Community Supports (ILOS) Provider Capacity Building and Community Supports (ILOS) Take-Up	Minimum of 30%	300	300
4. Quality	Optional measures with values allocated to either ECM or Community Supports (ILOS)	N/A To be allocated to ECM or Community Supports (ILOS) based on measure	N/A To be allocated to ECM or Community Supports (ILOS) based on measure
	Total Points	700	300

MCP can earn up to 1000 points across the full set of measures, including those listed here and in the accompanying excel Needs Assessment file. If an MCP achieves only a subset of measures, it will earn a partial payment.

Option for MCP to request more than 300 points to be allocated at their discretion. Please describe (in the box below) the preferred allocation and reason if MCP is requesting allocation different from that above. *100 word limit*

DHCS initially set gap-filling targets in the Reporting Template of at least 20%, based on the Gap-Filling plan. If gaps are lower than 30%, MCPs are expected to identify an appropriate gap-filling target in their narrative entry to be approved by DHCS. In instances where MCPs do not have a gap for the measure, they may propose an alternative target for achievement. DHCS will review all MCP-proposed gap filling targets and adjust those as needed to meet program requirements.

Narrative Measures for Priority Area 1: Delivery System Infrastructure

Gap-Filling Plan

1.1.6 Measure Description

Mandatory
80 points

Submission of a narrative Gap-Filling plan describing how MCPs will identify underserved populations and the ECM providers they are assigned to, and enhance those ECM Providers' capabilities to:

(1) Electronically exchange care plan information and clinical documents with other care team members.
(2) Have access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan.
(3) Submit a claim or invoice to an 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.

MCPs should also describe any plans to build physical plant (e.g., sobering centers) or other infrastructure to support the launch of ECM and Community Supports (ILOS).

Gap-Filling Plan narrative should include approaches for collaborating with entities, including but not limited to, county social services, county behavioral health, public healthcare systems, county/local public health jurisdictions, community based organizations (CBOs), correctional partners, housing continuum and others within the county to achieve the above activities, and should describe how health plans will leverage existing WPC infrastructure, including how they will track the ongoing viability of WPC infrastructure and improve data integration across behavioral health and physical health providers.

MCP Submission	
1. Describe approach to identify top 3-4 underserved populations in County and the ECM providers they are assigned to *100 word limit*	CCHP will identify disparities amongst population groups using internally developed datasets and DHCS provided disparity data. The CCHP quality and business intelligence teams will look at outcomes stratified by age, sex, race, ethnicity, geography, and housing status to identify underserved populations. The identified populations will be cross referenced with those eligible for ECM. Those members in the underserved populations who are eligible for ECM will be identified alongside their ECM provider. These members will be identified to ECM providers so ECM providers can partner on overall health plan priority initiatives as it related to health disparities.
2. Describe 3-4 concrete steps MCP will take to increase, by at least 20%, ECM Provider capabilities to electronically exchange care plan information and clinical documents with other care team members *100 word limit*	"CCHP will develop electronic dashboards to securely share information with ECM providers as well as technical tools for providers to submit ECM referrals electronically to the health plan for authorization and receive electronic notifications upon authorization. CCHP will develop electronic consent tools and workflows to support data exchange and information sharing across care team members. Building on existing infrastructure, the CareEverywhere healthcare information exchange will facilitate sharing of care plan and clinical information with care team providers on the Epic system, the majority of providers in Contra Costa county. Providers who do not use the Epic system will have access to the CCHP Provider Portal, to view authorization information and claims status. CCHP is ensuring groups have the proper access through the portal to view clinical data and the client's care plan as well."
3. Describe 3-4 concrete steps the MCP will take to increase, by at least 20%, ECM Provider access to certified EHR technology or a care management documentation system able to	CCHP will support the development of a Care Management information system for use by ECM providers through (1) direct funding for the IT system and technical implementation assistance. (2) The health plan will assist in the development of business requirements to support vendor selection in accordance with regulatory and reporting needs of CalAIM, including required Care Plan elements and the ability to collaborate with other care team members. (3) CCHP will participate in project Steering Committee meetings as a key stakeholder.

generate and manage a patient care plan *100 word limit*	
4. Describe 3-4 concrete steps the MCP will take to increase, by at least 20%, ECM Provider abilities to submit a claim or invoice to an 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 *100 word limit*	(1) CCHP will develop an excel invoice template to support the submission of claims information from providers unable to submit an electronic claim and (2) supplementary educational materials to support submission. This invoice template will be able to be submitted electronically for ease of use by providers. Information ingested from the invoice template will then be converted to encounter data for claims submission to DHCS. (3) The health plan will also expand the technical capabilities of the existing electronic provider portal to allow for the direct submission of claims information for providers who desire to submit claims data in a more real-time fashion.
5. Describe approaches for collaborating with, Social Services, County Behavioral Health, and County/Local Public Health Agencies within the county to improve data integration and electronic data	Contra Costa county has an advanced healthcare IT infrastructure with many existing data connections across the domains of physical, mental, and social healthcare services. Aided by a centralized county umbrella structure, data access across many different divisions is possible through a variety of data sharing agreements. CCHP will work to streamline this system by centralizing data sharing across divisions and updating existing data sharing agreements and establishing new ones as needed. Improvements will be made to information sharing with the Homeless Management Information System (HMIS), sharing with the social services division to improve Medi-Cal retention, and the centralization of patient contact information to aid in direct care outreach. In preparation for the expansion of ECM to future populations of focus, CCHP

sharing, capabilities among physical health, behavioral health and social service providers *100 word limit*	will work with the social service and health agencies to improve data collection and collation of information related to individuals in congregate living and detention facilities.
6. Describe approach for leveraging existing WPC infrastructure (if in WPC county), including tracking the ongoing viability of WPC infrastructure and improving data integration across behavioral health and physical health providers *100 word limit*	Contra Costa made significant investments in IT infrastructure during the Whole Person Care pilot and expects to continue to utilize these directly as well as use CalAIM incentive funds to fill known gaps. Building on the WPC success, CCHP will increase machine learning and technical automation to support administrative functions where possible. Risk stratification tools developed for WPC will expand to the full CCHP population to support identification of care management and population health program eligibility. Foundations of dashboards, reporting tools, and care plans developed for WPC will be the building block for ECM providers in the migration to a new electronic care plan.
7. Any additional Information on Delivery System Infrastructure Gaps in County *100 word limit*	"Currently, not all primary care and specialty care providers in the county have direct access to much of the social services data. CCHP would like to explore whether the data sharing agreements will allow for sharing with primary care providers and specialists beyond ECM care plans, especially for those providers who are not part of the existing county infrastructure."

Narrative Measures for Priority Area 2: ECM Provider Capacity Building

Gap-Filling Plan

1.2.5 Measure Description *Mandatory* *70 points*	
Submission of a narrative Gap-Filling plan demonstrating: (1) How the MCP will address identified gaps in ECM Provider capacity for Program Year 1 Populations of Focus. (2) Identified ECM workforce, training, TA needs in county, including specific cultural competency needs by county. (3) Plan for ECM Provider workforce recruiting and hiring of necessary staff to build capacity. (4) Approach for MCP to develop and administer an MCP training and TA program for ECM Providers. (5) Strategy to ensure ECM Providers are successfully engaging with hard to reach Populations of Focus, including homeless and justice involved populations, among others. (6) Approach to build, develop, or invest in the necessary behavioral health workforce to support the launch of ECM Gap-Filling Plan narrative should include approach for collaborating with other entities, including but not limited to, county social services, county behavioral health, public healthcare systems, county/local public health jurisdictions, community based organizations (CBOs), correctional partners, housing continuum, Tribes and Tribal providers (except for Plans in Counties without recognized Tribes), ECM providers and others to achieve the above activities, improve outreach to and engagement with hard to reach individuals within each Populations of Focus and reduce underlying health disparities	
MCP Submission	
1. Describe approach to address identified gaps in ECM Provider capacity for Program Year 1 Populations of Focus and proposed targets,	CCHP will establish data infrastructure to continuously monitor the eligible population, provider capacity, and monthly churn. During PY 1 CCHP will support ECM providers in filling vacant positions as well as standardization of case management services, workflows, and documentation tools. Standardization efforts and adoption of new IT tools, including a new Care Management information system, will support ECM providers in building technical capacity to serve ECM populations of focus. Additionally, CCHP will support ECM providers in centralizing services within a single organizational structure. Alignment of services across providers will allow for re-allocation of administrative resources and increase service delivery

of at least 20% improvement, to address gaps *100 word limit*	capacity. Finally, CCHP is in the process of recruiting and vetting additional ECM providers as another way of expanding capacity and addressing gaps.
2. Identify ECM workforce, training, and TA needs in county, including specific cultural competency needs by county *100 word limit*	CCHP will support ECM providers in establishing training infrastructure for staff onboarding and ongoing competencies. Curriculum will be inclusive of use of IT tools, documentation standards, and best practices for case management service delivery. CCHP will provide review and assistance of training materials to ensure alignment with linguistic and cultural competency standards, including specific strategies for engaging members experiencing homelessness – identified as the largest population of focus among CCHP membership. Additionally, CCHP will support ECM providers with onboarding to a new Care Management information system through direct funding for the IT system, project FTEs, and technical implementation assistance. Finally, CCHP will work to provide TA on how ECM providers can both integrate/collaborate with both primary care providers/care teams and inpatient providers/care teams.
3. Describe plan for ECM Provider workforce recruiting and hiring of necessary staff to build and increase capacity by at least 20% *100 word limit*	The ECM Provider workforce will be hired from existing County classifications across Contra Costa Public Health, Behavioral Health, and Social Service Divisions. Use of existing classifications will reduce recruitment delays while providing access to a diverse pool of specialty staff capable of serving the ECM Populations of Focus. During PY 1 CCHP will support ECM providers in filling vacant positions as well as standardization of case management services, workflows, and documentation tools across divisions. Additionally, CCHP is exploring and vetting additional ECM providers to provide services as a second way of building and increasing capacity by at least 20%. If selected as ECM providers, CCHP would assist these providers in recruitment and hiring necessary staff through advertising and technical assistance, as needed.
4. Describe approach to develop and administer an MCP training and TA program for ECM Providers	CCHP developed an ECM Provider Playbook and hosted technical assistance sessions to orient contracted and prospective Providers on ECM requirements and workflows. Content will be delivered across multiple sessions with specific trainings covering referral and authorization of ECM services, claims/invoicing requirements, and implementation of CalAIM population health initiatives including step-down pathways for patients ready to transition to lower levels of care via complex and basic case management. Additionally, CCHP will

100 word limit	establish monthly Joint Operations Meetings with ECM providers to discuss operational challenges and elicit additional training topics to support providers in ECM service delivery. ECM Providers will be invited to attend the Quarterly Provider Training to ensure they receive updates on the program. Finally, based on the identified topics, CCHP will host focused TA and learning collaborative sessions for the ECM providers.
5. Describe strategy to ensure ECM Providers are successfully engaging with hard to reach Populations of Focus, including homeless and justice involved populations, among others *100 word limit*	CCHP will develop data dashboards to identify disparities in program uptake among racial, ethnic, age, geographic, and Population of Focus groups. Data will be tracked over time and shared with ECM providers to support additional outreach and resources aimed at closing gaps in engagement. For members experiencing homelessness, CCHP will expand on existing data integration between the county's EHR and HMIS systems to support ECM Providers in identifying and connecting with members living at a shelter or encampment site. Lastly, CCHP will focus resources on developing new partnerships, workflows, and technical tools to serve justice involved populations beginning in 2023. CCHP will also host TA/learning collaboratives based on challenges identified in these areas.
6. Describe approaches for collaborating with, Social Services, County Behavioral Health, and County/Local Public Health Agencies within the county to achieve the above activities *100 word limit*	To support collaboration and standardization of services across agencies, contracted country ECM providers will centralize ECM services within a single organizational structure, bringing teams from Behavioral Health, Social Service, and Public Health division's together in an integrated service delivery model. Integration will allow for direct coordination among providers who traditionally care for the ECM populations of focus and support cross departmental workflow development as additional populations and shared patients are phased in over time. For noncounty ECM providers, CCHP will lead data sharing efforts with county, troubleshoot specific challenges that arise, and lead regular TA/learning collaboratives with participants from County Social Services, Behavioral Health, and/or Public Health as appropriate.

7. Describe approach to build, develop, or invest in the necessary behavioral health workforce to support the launch of ECM *100 word limit*	CCHP will partner with Contra Costa Behavioral Health Services to build workforce capacity among staff serving members with complex mental health and substance use needs. Investments will include increasing the total number of care team FTE's as well as technical support for workflow standardization and adoption of new IT tools. During PY 1 the ECM Behavioral Health workforce will onboard with a new care management platform and standardized ECM documentation tools. The new module will allow for greater coordination and less duplication of services between ECM Behavioral Health staff and other care team providers using the EHR.

Community Partners

1.2.6 Measure Description *Optional* *Report on One Optional Measure in ECM Provider Capacity Building Priority Area to Earn 30 Points*	
Narrative summary that outlines landscape of Providers, faith-based groups, community-based organizations, and county behavioral health care providers and county behavioral health networks in the county and submission of a narrative plan to develop an MOU or other agreements with a subset of Providers, faith-based groups, county agencies and community-based organizations in the county to develop strategies for closing health disparities experienced by Populations of Focus, including agreement to meet at least quarterly to advance strategy.	
MCP Submission	
1. Describe the landscape in the county of: a. ECM b. Providers c. Faith-based groups d. Community-based organizations	CCHP's initial ECM providers are embedded within the county's existing safety-net system, largely centralized within the publicly run system, Contra Costa Health Services (CCHS). CCHS is a highly integrated health system, operating a public hospital, twelve FQHCs, Behavioral Health Services (including both mental health and alcohol and other drugs), county detention health services, public health, Emergency Medical Services, Environmental Health, and Health, Housing and Homeless department. CCHS provides coverage and care for over 200,000 individuals in the County and works closely with other health systems, providers, and networks of community-based organizations, and interfaith across the county

e. County behavioral health care providers and county behavioral health networks *100 word limit*	
2. Describe approach to foster relationships with a subset of the organizations described above in 1. Approach should include at least quarterly meetings, and can potentially include and MOU or letter of agreement *100 word limit*	CCHP has a MOU with CCHS Public Health and Behavioral Health Services as ECM providers. CCHP hosts a Safety Net Provider Meeting every other month. At these meetings policy updated on the ECM/CS benefits are discussed. County BH meets with CCHP Monthly and ECM updates will be discussed. In addition, ECM Providers are invited to our Quality Council at least quarterly. At our Managed Care Commission Meeting Quarterly we will invite the Community Support providers to attend so we can further develop relationships and a deeper connection to the community. CCHS also has a Chief Equity Officer who has worked closely with CCHP and both faith-based groups and community based organizations for the COVID-19 response. CCHP will leverage these relationships to further engage both faith-based groups and CBOs.
3. Describe the strategy for closing identified health disparities with at least one strategy for each population of focus that will go	For identified disparities CCHP will (1) support expansion of Medi-Cal Eligibility Workers across ECM providers to address retention and churn among the homeless population. (2) Launch Recuperative Care and Short-Term Post Hospitalization Community Supports to support discharge to appropriate recovery settings for homeless patients (3) Participate in a county-wide collaborative to link patients with SMI to behavioral health crisis services. (4) Address gaps in health system literacy among high utilizers through ECM care management activities including education on health system usage and navigation. (5) Expand expediated processing

live in the County in 2022, for a total of at least five identified health disparities *100 word limit*	of IHSS program intakes and re-assessments for high utilizer populations to reduce avoidable admissions.

Tribal Engagement

1.2.7 Measure Description *Mandatory 30 points*	
Narrative summary that outlines landscape of Tribes, Tribal providers used by members in the county, and members in the county who use Tribal services, and submission of a narrative plan to develop an MOU to establish a strategic partnership with Tribes and Tribal providers in county to develop Provider capacity and provision of ECM services for members of Tribes	
MCP Submission	
1. Outline the landscape of Tribes, Tribal providers, and members in the county who use Tribal services and will need ECM supports *100 word limit*	There are 576 members who identify as American Indian or Alaskan in the Plan. There are no IHFs in Contra Costa, but the Plan has received DHCS's list of IHF facilities in the surrounding counties. Using this information, the Plan has collected the contact information of these entities with the intent to forge alliances with these groups in 2022 Q1 to better understand the needs of its members, supporting Tribal providers, and use of tribal services in surrounding counties. Per CCR Title 22 § 55110 provision (b) – Indians who are enrolled in a Medi-Cal managed care plan, including county organized health systems, shall not be restricted in their access to Indian Health Service Facilities by the Medi-Cal managed care plan. Additionally in Title 22 § 55120 IHFs can voluntarily enter into a contract with an MCP at any time. MCPs that are unable to contract with an IHF must allow eligible members to obtain services from out-of-network (OON) IHFs.

	Per Federal Medicaid rules, APL 21-006, and APL 21-008 CCHP(as a Medi-Cal Managed Care Plan) is required to contract with each willing Indian Health Facility (IHF) if and when those institutions enter into Contra Costa County. IHFs that enter into Conta Costa County, can voluntarily enter into a contract with an MCP at any time. As of January 1, 2022, all tribal members can choose to enroll in a Medi-Cal Managed Care Plan and also receive care at tribal health facilities. As these members enroll in CCHP, CCHP will reach out to their tribal health providers to coordinate care. We will reach out to their tribal primary care providers as noted by care individual plan needs.
2. Outline a plan to establish a strategic partnership including any plans for formalization such as a MOU or other agreements *100 word limit*	There are no Indian Health Facilities in Contra Costa County as of January 1, 2022. However, CCHP has received DHCS's list of IHFs in neighboring counties and intends to forge alliances with those organizations in Q1 2022. CCHP affirms its intention to explore engagement opportunities with those IHFs, who can help identify pathways to support tribal providers located in Contra Costa County, and to form strategic partnerships as well as help develop provider capacity and ECM services to AI/AN members.
3. Describe plan to develop provider capacity and ECM services for members *100 word limit*	In addition to 1.2.7(2), CCHP will engage it's Provider Relations and Contracting Department to do outreach to the various CBOs or organizations that provide ECM like services for the AI/AN communities, to apply to be a network provider. CCHP's goal is to ensure at a 100% that the ECM Network is at a full capacity. Annually we will announce to our Provider Network they can refer a CBO to our network.

Engagement for Key Population of Focus: People Experiencing Homelessness or Chronic Homelessness

1.2.9 Measure Description *Mandatory 30 points*
Submission of narrative plan describing how the managed care plan will improve outreach to and engagement with the following 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," with a focus on Black/African American and other racial and ethnic groups who are disproportionately experiencing homelessness
MCP Submission

1. Identify and describe top 3 – 4 racial and ethnic groups that are disproportionately experiencing homelessness in the county *100 word limit*	"Racial composition of those experiencing homelessness in Contra Costa County:39% of our homeless population identifies as African American (vs 10% of CCC population)7% of our homeless population identifies as Native American (vs 1% of CCC population)6% of our homeless population identifies as mixed/multiple race (vs. 5% of CCC population)"
2. Describe approach to improve outreach and engagement by at least 20% to Black/African American and other racial and ethnic groups who are disproportionately experiencing homelessness *100 word limit*	"CCHP will work with ECM providers as well as the County Health, Housing and Homelessness team to identify best practices on outreach and engagement of all racial/ethnic groups disproportionately experiencing homelessness. Once these best practices are identified, CCHP will work to host TA/learning collaboratives focused on these topics with ECM providers and experts in this area as well as discuss these strategies at CCHP's Managed Care Commission, Safety Net Council, and Quality Council meetings.Develop BIPOC outreach and engagement plan based on equity assessment currently being conducted within H3. Preliminary concepts including, increasing the number of outreach teams in areas identified as disproportionately BIPOC and increase number of BIPOC staff on teams to better reflect population served. Provide additional technical assistance to organizations serving primarily BIPOC communities to ensure quality of service."

Engagement for Key Population of Focus: Individuals Transitioning from Incarceration

1.2.10 Measure Description *Optional* *Report on One Optional Measure in ECM Provider Capacity Building Priority Area to Earn 30 Points*
Submission of narrative plan describing how the managed care plan will improve outreach to and engagement with the following Population of Focus: "individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community," with a focus on Black/African American and other racial and ethnic groups who are disproportionately experiencing transitions from incarceration settings in the county.

MCP Submission	
1. Identify and describe top 3 – 4 racial and ethnic groups that are incarcerated in the county *100 word limit*	The Plan selects this optional measure. The top racial/ethnic groups incarcareted in the county (by numbers) are: black (588), nonHispanic white (477), and Hispanic/LatinX (365) of 1454.
2. Describe approach to improve outreach and engagement by at least 20% to Black/African American and other racial and ethnic groups who are disproportionately experiencing transitions from incarceration settings in the county *100 word limit*	"With ECM being implemented for those who are justice involved starting January 1, 2023, CCHP intends on setting up a series of meetings with both the law enforcement and correctional health teams with ECM provider leadership during the course of 2022 to identify best ways to help ensure safe and seamless transitions for high-risk and disproportinately affected groups. CCHP will also include community-based and faith-based organizations in these discussions as well as leaership from top safety-net primary care providers in the county. Once these best practices are identified, CCHP will work to host TA/learning collaboratives focused on these topics with ECM providers and experts in this area as well as discuss these strategies at CCHP's Managed Care Commission, Safety Net Council, and Quality Council meetings. Ideas include, hiring a reentry services specialist at the Martinez Detention Facility, West County Detention Facility and Marsh Creek Detention Facility. The re-entry specialist will be the primary point of contact supporting incarcerated individuals, especially those who are receiving mental health services. Reentry activities comprise of developing reentry plans with participants, in facility discharge planning to crisis residential programs for acute mental health challenges and other housing; facilitating discharge planning groups; coordinating with justice partners and community-based providers; assisting financial counselors with Medi-Cal applications; participating in multi-disciplinary case conferences, and collaborating with other Detention Health and Custody staff.The reentry specialist will proactively engage individuals with anticipated release dates, frequent incarcerations and prolonged stays at detention. Outreach efforts include drop in hours on the housing modules and buildings to invite unscheduled walk up visit, joining patient visits with physical and mental health staff to support discharge planning, and working with reentry services embedded within detention and transition services with community partners."

Narrative Measures for Priority Area 3: Community Supports (ILOS) Provider Capacity Building & Take-Up

Gap-Filling Plan

1.3.5 Measure Description *Mandatory* *80 points*
Submission of a narrative Gap-Filling plan describing: (1) Identified gaps or limitations in Community Supports (ILOS) coverage within county (2) Plan to increase number and/or reach of Community Supports (ILOS) offered in January 2022 or July 2022 (3) Identified Community Supports (ILOS) Provider capacity and MCP oversight capability gaps and plan to address gaps (4) Identified Community Supports (ILOS) workforce, training, TA needs in region / county, including specific cultural competency needs by region/county (5) Plan to develop and administer a training and TA program for Community Supports (ILOS) Providers (6) Plan to establish programs to support Community Supports (ILOS) workforce recruiting and hiring, including incentives for Community Supports (ILOS) Providers to hire necessary staff Gap-Filling Plan narrative should include approach for collaborating with other entities, including but not limited to, county social services, county behavioral health, public healthcare systems, county/local public health jurisdictions, community based organizations (CBOs), correctional partners, housing continuum, Community Supports (ILOS) providers, and others to achieve the above activities, improve outreach to and engagement with hard to reach individuals and reduce underlying health disparities.

MCP Submission	
1. Describe 3-4 identified gaps or limitations in Community Supports (ILOS) coverage within the county. If the Community Supports (ILOS) Provider network/capacity will not reasonably allow for county-wide provision of Community Supports (ILOS) to all eligible Members in the county at the time of implementation, please provide a brief explanation.[1] *100 word limit*	The Asthma Remediation Program will need an expansion in capacity. CCHP will work with the local American Lung Association and Community providers to expand capacity to be able to serve all identified asthmatic members who need home remediation. A survey of CBO's in the marketplace will assist CCHP in broadening this CS service. At the 6th month interval we will have an evaluation of more potential providers. The medical respite provider in Contra Costa County has limited capacity currently. CCHP is reaching out to medical respite providers in neighboring counties to increase overall capacity. CCHP will also engage in discussions with the medical respite facility about increasing capacity in order to be able to offer this service county-wide. Finally, the post-hospital stabilization housing provider has limited capacity at this time. CCHP is piloting the model with this provider to develop best practices. Once best practices are established, CCHP will work with the provider to expand capacity and explore additional providers if needed to be able to offer this service county-wide.
2. Describe the plan to increase number and/or reach of Community Supports (ILOS) offered in January 2022 or July 2022 *100 word limit*	CCHP's Provider Relations will send at inquiries to the various community-based organizations to determine their interest in providing the three community support services where CCHP has identified a need for increased capacity (asthma home remediation, medical respite, and post hospital stabilization housing). This includes queries to our 3 delivery systems: John Muir, Sutter and CCRMC to determine their services and the capacity to serve CCHP members when it comes to community supports. Additionally, CCHP plans on developing a deeper understanding of the eight additional community supports and hopes to offer many of them starting January 2023.

[1] This submission should align with information submitted in the ECM and Community Supports (ILOS) Model of Care Template.

3. Identify Community Supports (ILOS) Provider capacity and MCP oversight capability gaps and plan to address gap with a gap closure of 20% *100 word limit*	For capacity, we have identified gaps with respect to asthma home remediation, medical respite, and hospital post stabilization housing. As discussed above, for respite we are working on contracting with repite provider(s) in adjacent counties. Our estimation is based off the utilization of respite care from the previous 2 years and examining the bed capacity both in Public Health and the Homeless Program. For asthma, we are reaching out to CBOs and other providers of home remediation services. For post-hospital stabilization housing, we are working with our current provider to expand capacity. For oversight, we are building out an oversight team and hiring new staff to ensure accurate capacity for oversight.
4. Identified Community Supports (ILOS) workforce, training, TA needs in region / county, including specific cultural competency needs by region/county, and a training gap closure of at least 20% *100 word limit*	The Plan will provide training on connecting providers with their patients via a Cultural Competency training to help providers understand culture and cultural competence, strive towards clear communication and using interpreter services and translation, obtain a better understanding (LGBTQ) communities and health disparities, address health care for refugees and immigrants, and reflect on strategies to support seniors and people with disabilities. Additionally the Plan will provide additional resources on literacy issues, pain management across cultures and laws and standards related to cultural issues. In addition, all Community Supports providers are required to attend a Provider Training within 10 days of being a provider. The Cultural Competency Training is included in the on-boarding. Annually we will reach out to providers to take this training online for new staff or a refresher training for existing staff. In addition in our Quarterly Provider Trainings and newsletter we will cover the requirements for cultural competency. For TA needs, we are working with the providers to ensure streamlined submission of referrals, claims, and encounter data as well as identifying best practices, connections/communications with healthcare providers, and integration with ECM, healthcare, and social service providers.
5. Plan to develop and administer a training and TA program for Community Supports (ILOS) Providers *100 word limit*	CCHP will enhance out online training and a certificate of completion for Community Supports Providers. Our current Cultural Competency Training is geared for medical providers. Within Q1 we will upgrade this training to fit the needs of the Community Support Providers. We will request one of the providers take this training and provide feedback on their experience so we can have a separate training online specifically for Community Supports providers. Additionally, CCHP will host regular TA sessions on

	identified needs, including, but not limited to referral/claims/encounter data submission, connection/communication with healthcare and social service providers, and other topics based on needs as identified by Community Supports Providers.
6. Plan to establish programs to support Community Supports (ILOS) workforce recruiting and hiring, including incentives for Community Supports (ILOS) Providers to hire necessary staff, and increase Community Supports (ILOS) workforce by at least 20% *100 word limit*	CCHP will make grants available to CBOs who wish to be a Community Supports provider to support recruitment efforts to hire additional staff. CCHP will assist community partners in accessing any local funding through the County or other healthcare organizations that provide funding such as grants offered by the California Wellness Foundation and other for profit organizations that give back to the community that supports social determinants of health. CCHP will also leverage its network to help with advertising and recruitment for staff.
7. Describe approach for collaborating with, Social Services, County Behavioral Health, and County/Local Public Health Agencies within the county to achieve the proposed activities *100 word limit*	CCHP is owned by Contra Costa County and embedded as a division in the Health Service System. Our staff are part of many collaboratives with County Public Health, County Behavioral Health and Social Services. Therefore we will continue to enhance and build off our existing relationships. Weekly the CCHP Team is part of various meetings and activities to include our Quality, Member Services, Case Management teams are already at the table with the other County Divisions.

Tribal Engagement

1.3.6 Measure Description *Mandatory 20 points*	
Narrative summary that outlines landscape of Tribes, Tribal providers in the county, and members in the county who use Tribal services and submission of a narrative plan to develop an MOU to establish a strategic partnership with Tribes and Tribal providers in county to develop Provider capacity and provision of Community Supports (ILOS) services for members of Tribes	
MCP Submission	
1. Outline the landscape of Tribes, Tribal providers, and members in the county who use Tribal services and you anticipate will use Community Supports (ILOS) *100 word limit*	There are 576 members who identify as American Indian or Alaskan in the Plan. There are no IHFs in Contra Costa, but the Plan has received DHCS's list of IHF facilities in the surrounding counties. Using this information, the Plan has collected the contact information of these entities with the intent to forge alliances with these groups in 2022 Q1 to better understand the needs of its members, supporting Tribal providers, and use of tribal services in surrounding counties. Per CCR Title 22 § 55110 provision (b) – Indians who are enrolled in a Medi-Cal managed care plan, including county organized health systems, shall not be restricted in their access to Indian Health Service Facilities by the Medi-Cal managed care plan. Additionally in Title 22 § 55120 IHFs can voluntarily enter into a contract with an MCP at any time. MCPs that are unable to contract with an IHF must allow eligible members to obtain services from out-of-network (OON) IHFs. Per Federal Medicaid rules, APL 21-006, and APL 21-008 CCHP(as a Medi-Cal Managed Care Plan) is required to contract with each willing Indian Health Facility (IHF) if and when those institutions enter into Contra Costa County. IHFs that enter into Conta Costa County, can voluntarily enter into a contract with an MCP at any time. As of January 1, 2022, all tribal members can choose to enroll in a Medi-Cal Managed Care Plan and also receive care at tribal health facilities. As these members enroll in CCHP, CCHP will reach out to their tribal health providers to coordinate care. We will reach out to their tribal primary care providers as noted by care individual plan needs.
2. Outline a plan to establish a	There are no Indian Health Facilities in Contra Costa County as of January 1, 2022. However, CCHP has received DHCS's list of IHFs in neighboring counties and intends to forge alliances with

strategic partnership including any plans for formalization such as a MOU or other agreements *100 word limit*	those organizations in Q1 2022. CCHP affirms its intention to explore engagement opportunities with those IHFs, who can help identify pathways to support tribal providers located in Contra Costa County, and to form strategic partnerships as well as help develop provider capacity and ILOS services to AI/AN members.
3. Describe plan to develop provider capacity and Community Supports (ILOS) services for members *100 word limit*	Although CCHP does not have contracts with Indian Health Facilities at the time of submission, we will continually evaluate network and contracting opportunities for Community Supports that will support Tribal and all CCHP members; and collaborate with plan and county partners to enhance workforce development and pipeline. This could include providing technical assistance and training; and supporting providers (including IHFs) in expanding their footprint. These approaches will help develop capacity that will support Tribal members in accessing Community Supports services

Collaboration with Other MCPs

1.1.7 Delivery System Infrastructure Building Measure Description *Mandatory 20 points*
Submission of a narrative describing how the MCP will collaborate with all MCPs in the county to enhance and develop needed ECM/ Community Supports (ILOS) infrastructure, including certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities and submission of documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing ECM and Community Supports (ILOS) capacity building approaches
MCP Submission *100 word limit*
CCHP will form a quarterly collaborative partnership that includes Kaiser as the plan partner and Anthem Blue Cross as the private plan in our two plan model. Prior to the ECM benefit going live we were meeting twice a month. We will develop a MOU with Anthem that will outline the sharing of Best Practices and put together an ECM Charter. In addition we will involve other CBOs to join these meetings to stay connected with the outcomes of the ECM Benefit along with Community Supports (CS) Services. CCHP already has a relationship with Anthem Blue Cross. During the preparation phase for the launch of ECM, the Plan had regulator meetings with Anthem. The Plan will be meeting in February to continuing exploring collaborative opportunities to benefit those who are eligible to receive them in Contra Costa County. The Plan expects to leverage the existing MOU with Anthem and County Public Health, since we are a part of that health Delivery System. Tangible topics for February 2022's meeting include strategizing on various IT platforms and how the entities can interface with each other to maximize ECM/CS Services.

1.2.8 ECM Provider Capacity Building Measure Description *Mandatory* *10 points*
Submission of a narrative describing how the MCP will collaborate with all MCPs in the county to support expansion of ECM Provider capacity, including leveraging and expanding existing WPC capacity and building/expanding ECM Provider networks and compliance and oversight capabilities. MCP should also submit documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing ECM capacity building approaches
MCP Submission *100 word limit*
CCHP will partner with Anthem and compare the ECM provider network along with the Community Supports service provider. We will reach out to providers that may not be contracted in both networks. Also during our monthly meetings with minutes and a Action Plan we will discuss oversight and compliance with the Model of Care and evaluate whether our policies are aligned. CCHP will recommend that we develop an auditing tool that we share when we do our oversight to ensure compliance. We will develop outreach criteria, so we are using similar tactics for expanding the provider network capacity for services to the county population, as a whole. We will also consider doing joint contracting. In addition we will add Kaiser as a plan partner so that all the MCPs meet and perform audits jointly and benchmark for best practices for the administration of the ECM Benefit along with Community Supports services.

1.3.7 Community Supports (ILOS) Provider Capacity Building and Community Supports (ILOS) Take-Up Measure Description *Mandatory* *50 points*
Submission of a narrative describing how the MCP will collaborate with all MCPs in the county to leverage and expand existing WPC capacity and support ongoing Community Supports (ILOS) capacity building approaches. MCP should also submit documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing Community Supports (ILOS) capacity building approaches
MCP Submission *100 word limit*
CCHP will establish a Monthly Calendar of meetings with Anthem and Kaiser. This collaboration will start in February 2022 until December 2022 for year 1. We will discuss creating a Charter for the MCPs to work together along with documented minutes and determine an Action Plan to address any deficiencies and perform a county-wide evaluation of ECM and Community Supports (CS) to determine if additional CS services will expand beyond the 6 started in January. Also we will share a cost effective model for a comprehensive approach for CS services. CCHP will sign a Charter with Anthem that defines how we will work together