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	Inland Empire Health Plan
MCP County	Riverside County
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	100
2. ECM Provider Capacity Building	Minimum of 20%	200	100
3. Community Supports (ILOS) Provider Capacity Building and Community Supports (ILOS) Take-Up	Minimum of 30%	300	100
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*	It is critical that ECM services be delivered to eligible health plan Members in a way that supports health equity. For this to be the case, the characteristics of the ECM-enrolled population should reflect those of health plan membership that is eligible; subgroups underrepresented in the enrolled population might represent gaps in outreach/enrollment to individuals most in need of these services. We will monitor the racial/ethnic, language, geographic, and housing status characteristics of enrollees into ECM and work to focus community partnership and outreach efforts to ensure enrollees represent the population of all eligible Members.
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*	To support the electronic exchange of care plans/clinical documentation among ECM care team members, the health plan will: 1) work with its ECM software vendor (Allscripts – Care Director platform) to integrate and display claims, authorization, and eligibility data; 2) work with county partners to integrate their EHR systems with Care Director; and 3) leverage incentives to hire additional Information Technology (IT) team members to support this work (two software engineers, two data integration programmers). Goals: additional IT team members hired by end of Q1 2022; 100% of contracted ECM Providers using updated Care Director by end of Q4 2022.
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	To support ECM Provider access to a certified platform for clinical (including care plan) documentation, the health plan will: 1) use incentives to purchase Care Director licenses for newly contracted ECM Providers; 2) provide technical support to these newly contracted ECM Providers in the use of Care Director; and 3) build integration pathways between Care Director and other EHR platforms already in use by established ECM care teams. Goals: 20% of new ECM Provider practices live on Care Director integration by end of Q2 2022.

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*	To support the transition of ECM Providers to billing claims, the health plan will: 1) update the existing Provider Portal for ECM Providers to submit claims (e.g., for enrollee outreach attempts); 2) build data processes to translate online ECM claims submissions into DHCS encounter data for submission; and 3) use incentives to offer financial support to ECM Providers who elect to contract with claims clearinghouse vendors to avoid manual claims submission. Goal: 100% of contracted ECM Providers submitting claims by end of Q2 2022.
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	The health plan is actively building data sharing capabilities with partnering Riverside County agencies to support the launch of ECM and CS services. These capabilities include: bidirectional data sharing between the health plan and Riverside County Department of Behavioral Health; providing Care Director access and training to ECM teams housed within the county; and EHR integration (to complement Care Director) for Riverside University Health System.

sharing, capabilities among physical health, behavioral health and social service providers *100 word limit*	
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*	Whole Person Care (WPC) care teams (Riverside County) transitioning to become ECM Providers will shift to existing infrastructure for data sharing/integration already developed as part of the health plan's Health Homes Program (Care Director platform). In addition, the health plan's Member attribution algorithm is being updated by IT team members to ensure that former WPC participants (justice involved individuals) stay with their existing care teams as they transition into ECM.
7. Any additional Information on Delivery System Infrastructure Gaps in County *100 word limit*	There is a recognized gap in direct system-to-system integration between existing EHR systems in both Riverside County and health plan data systems. Currently, the Care Director platform and health plan Provider Portal serve as conduits to connect these systems. In the future, the health plan hopes to achieve direct integration with county data infrastructure to continue to support the expansion of CalAIM initiatives across the network.

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,	The health plan applied DHCS' ECM criteria to internal data to identify eligible Members in Riverside County. It is estimated that over 48,000 individuals will be eligible in 2022. The health plan's network of 52 Health Homes Program care teams will be transitioning to ECM Providers to serve most of these individuals. An additional 15 care teams (10 clinic-based ECM teams and 5 regional IEHP teams) will be added to increase capacity. IEHP will monitor team enrollment/overall caseload and adjust the number of network ECM teams to respond to the needs of eligible Members in Riverside County.

of at least 20% improvement, to address gaps *100 word limit*	
2. Identify ECM workforce, training, and TA needs in county, including specific cultural competency needs by county *100 word limit*	The health plan cross-walked the training components of the DHCS ECM program manual and existing Health Homes Program care team trainings. These trainings cover diverse clinical subjects and include focused curricula on health equity and cultural competency – critical gaps in knowledge among new Riverside County ECM care teams. Ongoing training needs will be continuously assessed via participant feedback captured via practice coach meetings, post-webinar discussions, leadership roundtables, and after other relevant learning sessions.
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 health plan will continue to support the expansion of the ECM Provider workforce by identifying those Providers with ECM eligible Populations of Focus and actively engaging them to become contracted ECM Providers. Incentives will be leveraged to offer ramp-up funding during the first six months of the contractual agreement, supporting the ECM care team hiring (Nurse Care Manager, Behavioral Health Care Manager, Care Coordinator, and Community Health Worker). Goal: 20% increase in total care team members hired by the end of Q4 2022.
4. Describe approach to develop and administer an MCP training and TA program for ECM Providers *100 word limit*	The health plan will adapt the centralized Health Homes Program training program to align with ECM requirements. This adapted training will be administered to clinic based and IEHP regional ECM care teams (including WPC teams transitioning to ECM). The training program centers on a practice coaching model that is supplemented with regular webinars, learning sessions, leadership roundtables, and discipline-specific training calls. The training curriculum includes a broad range of topics including core services, ECM procedures, and cultural competency.
5. Describe strategy to ensure ECM Providers are	To support equity in ECM implementation, it is critical that the health plan supports outreach to populations that may be underserved in such programs. This will be operationalized through: 1) training; 2) community partnerships; and 3) funding for additional Community

successfully engaging with hard to reach Populations of Focus, including homeless and justice involved populations, among others *100 word limit*	Health Workers. Focused training will be developed and delivered to care teams on skill development for outreach/engagement of Populations of Focus. ECM care teams will be connected to community partners (e.g., Community Supports Providers) to better connect to hard-to-reach populations. Additionally, reimbursement for outreach attempts will be part of ECM implementation.
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*	The health plan is contracting with Riverside County as an ECM Provider; Health Homes Program care teams will transition to ECM and new teams will also be added. Certain teams (e.g., those through the Department of Behavioral Health) will work with Populations of Focus that are difficult to engage. County ECM care teams will experience the same tailored trainings and learning opportunities described above.
7. Describe approach to build, develop, or invest in the necessary behavioral health workforce to support the launch of ECM *100 word limit*	Leveraging incentives, the health plan will offer newly contracted ECM Providers ramp-up funding during the first six months of the contractual term to support ECM care team hiring. Core care team members include a Behavioral Health Care Manager (with special skills in substance use disorder treatment/severe mental illness management for Behavioral Health teams). Care teams transitioning to ECM from WPC/the Health Homes Program will continue to receive training and practice coaching to advance behavioral health best practices.

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 e. County behavioral health care providers and county behavioral health networks *100 word limit*	The landscape of county agencies, community-based organizations (CBOs), and faith-based groups will be engaged to build ECM capacity. The Riverside County Department of Behavioral Health will bring on a new ECM care team to serve ECM enrollees with specific behavioral health needs. CBOs will serve as ECM care teams for key populations of focus (e.g., people experiencing homelessness). Existing health plan partnerships with the Catholic Diocese, Congregations Organized for Prophetic Engagement (COPE), Seventh Day Adventist leaders, and the African Methodist Episcopalian churches will be leveraged for ECM community education/outreach.

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*	The health plan has fostered relationships with ECM Providers using a combination of regular meetings (educational/operational) and formal contracts. These meetings engage county agencies and CBOs who provide ECM services. All ECM Providers (including Riverside County teams and CBOs working with specific populations) participate in all-team biannual learning sessions, monthly leadership round tables, and weekly (mandated) trainings for all ECM care team members. Participation in these activities has been formalized through inclusion in ECM Provider contracts. Regular outreach meetings are held with community partners (including regional faith-based entities) to inform leaders and congregations about ECM and the related services available.
3. Describe the strategy for closing identified health disparities with at least one strategy for each population of focus that will go live in the County in 2022, for a total of at least five identified health disparities *100 word limit*	The health plan has identified six quality (both process and outcome) metrics that will be monitored for ECM Populations of Focus enrolling in 2022. These measures will include: care planning and routine contact; blood pressure screening; blood pressure control; depression screening; depression response; and transition of care support. The health plan will apply these metrics across each Population of Focus. Performance data will be stratified to identify Member subpopulations who may be experiencing health disparities. Performance data will be shared with ECM care teams to support closing gaps.

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 10 federally recognized tribes in Riverside County. Seven of these tribes are contracted with Riverside San Bernardino Indian Health Clinic, Inc. – a health plan network federally qualified health center (FQHC; primary, specialty, and behavioral health services). Approximately 1,700 health plan Members receive care with the contracted FQHC – it is certain that some of these Members may be eligible for ECM.
2. Outline a plan to establish a strategic partnership including any plans for formalization such as a MOU or other agreements *100 word limit*	The health plan has been meeting with tribal partners to discuss how best to build on existing relevant provider contracts and develop new agreements to support ECM services for tribal-affiliated health plan Members. It is anticipated that the FQHC serving a number of these individuals may be interested in developing their own ECM care teams to provide tailored services to this special population.
3. Describe plan to develop provider capacity and ECM services for members *100 word limit*	IEHP regional care teams will provide ECM services to collaborate with all tribal FQHC facilities to enhance capacity and expand access to ECM services for eligible Members. In partnership with FQHCs serving tribal Members, health plan regional ECM care teams will provide ECM core services to ECM enrollees, including in-person home visits, accompaniment and coordination of care transitions. These health plan regional ECM care

	teams consist of a Nurse Care Manager, Behavioral Health Care Manager, Care Coordinator, and Community Health Worker.

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*	Riverside County's 2020 "Point-in-Time" survey of residents experiencing homelessness counted 2,155 individuals. Racial/ethnic demographics of this survey were compared to 2020 U.S. Census data for the county. Using this method, two subgroups were identified as disproportionately experiencing homelessness: Black/African American (24.5% experiencing homelessness versus 7.3% population composition) and American Indian/Alaska Native (3.3% versus 1.9%). This Riverside County finding is consistent with national homelessness data findings for 2020. Two additional race/ethnic groups comprising substantial proportions of the population experiencing homelessness included those identifying as White (77.8%) and Hispanic (41.8%).
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	From its existing pilot Housing Program, the health plan has gained experience in outreach and engagement to key subpopulations disproportionately experiencing homelessness. An evaluation of the first cohort of 162 Members enrolled into this pilot (which offers services like those included as part of ECM and Community Supports) demonstrated that 25% of participants identified as Black/African American (proportionate to population experiencing homelessness overall). A smaller percentage (1%) identified as American Indian/Alaska Native. The health plan will leverage relationships built with community partners in the Housing Program pilot as well as additional Community Health Workers to ensure ongoing equitable engagement.

experiencing homelessness *100 word limit*	

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 most recent data available (2016; California Sentencing Institute/Center for Juvenile and Criminal Justice) reveals that individuals who identified as Latinx were disproportionately incarcerated in Riverside County (46.1%). Those who identified as Black/African American also made up a significant proportion of the justice-involved population (6.6%). Riverside County's WPC population also is disproportionately Black/African American (12.3% - internal program data). This is consistent with state trends, where these same subpopulations account for more than their population share in both jails and prisons (source: Vera Institute of Justice/U.S. Bureau of Justice Statistics).
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	Riverside County's existing WPC program has focused on the justice-involved population; WPC teams and their enrollees will transition into ECM. Riverside County WPC teams have been successful in engaging Black/African American and Latinx enrollees per internal program data. These care teams have expertise in working with the diverse post-incarceration population. The health plan will leverage this expertise and work closely with these care teams to outreach to racial and ethnic groups disproportionately represented in this Population of Focus. This data will be used to assure effective and equitable engagement of patients into ECM services.

from incarceration settings in the county *100 word limit*	

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 provision of Community Supports (CS) to eligible Members across Riverside County will be limited by: 1) gaps in the breadth of CS types available in the network (Providers of day habilitation, respite services, and personal care have not yet been identified); 2) a lack of current CS Providers who offer services in geographically remote regions of Riverside County (compounded by health plan expansion into formerly "voluntary" zip codes); and 3) lack of CS Provider interest in contracting.
2. Describe the plan to increase number and/or reach of Community Supports (ILOS) offered in January 2022 or July 2022 *100 word limit*	To increase the number and reach of CS offered, incentives will support: 1) identification of, and capacity building for, day habilitation, respite services, and personal care Providers across Riverside County; 2) capital costs to support increased sobering center service capacity in Riverside County (partnership with county Department of Behavioral Health); and 3) outreach into newly added health plan zip codes to identify and contract with CS providers in outlying regions.

[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*	Related gaps exist in both the capacity of CS Providers to efficiently process service referrals and the capability of the health plan to monitor CS referral turnaround times (TAT). Today, CS Providers do not have access to a closed loop referral system. Incentives will be leveraged to build a health plan CS oversight team and closed loop referral system. Goals: 20% of contracted CS Providers have access to closed loop referral and have undergone referral TAT audit by Q2 2022.
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*	Among CS Provider organizations across Riverside County, training and technical assistance (TA) gaps have been identified in the areas of: claims billing/encounter submission; health plan benefits; diversity/cultural humility; grievance/appeals process; and compliance/data security. The health plan is adapting existing Provider trainings (leveraging existing Health Homes Program experience) for the CS workforce. The health plan will initiate this CS Provider training program with goals of training 20% of network CS Providers by the end of Q1 2022, and 100% of CS Providers by the end of Q4.
5. Plan to develop and administer a training and TA program for Community Supports (ILOS) Providers *100 word limit*	Incentives will be used to support the adaptation of existing health plan network Provider trainings to meet the needs of CS Providers. Tailored trainings will be developed in the areas of: claims billing/encounter submission; health plan benefits; diversity/cultural humility; grievance/appeals process; and compliance/data security. Additionally, incentives will be used to develop health plan infrastructure to both train CS Providers and provide ongoing TA as CS services scale to all eligible Members. A team of health plan "CS liaisons" will be built to ensure CS Providers are supported as they begin to serve Members across both counties.
6. Plan to establish programs to support Community Supports	It is anticipated that CS Providers across all offered services will benefit from incentives to hire staff focused on billing and administration. Health plan billing – a novel process to CS Providers – warrants incentives for workforce development. Additional focused incentives

(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*	for hiring will be allocated to CS housing service Providers. Housing service Providers will need additional support in building their teams to meet an expanded population of eligible Members. These investments will be made with the goal of increasing the health plan's contracted CS workforce (count of contracted organization team members) by 20% before the end of Q4 2022.
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*	The health plan will directly contract with public agencies in Riverside County to achieve success in offering CS services to eligible Members. Riverside University Health System (encompassing public health, social services, and behavioral health agencies) will contract to provide CS housing services and a sobering center. These county agencies have existing expertise in providing housing and behavioral health services. They have existing connections to public programs that will complement CS benefits (e.g., employment, probation). In this way, county partners will serve as "one door" to CS for eligible Members.

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 10 federally recognized tribes in Riverside County. Seven of these tribes are contracted with Riverside San Bernardino Indian Health Clinic, Inc. – a health plan network FQHC (primary, specialty, and behavioral health services). Approximately 1,700 health plan Members receive care with the contracted FQHC – it is certain that some of these Members may be eligible for Community Supports.
2. Outline a plan to establish a strategic partnership including any plans for formalization such as a MOU	The health plan is meeting with tribal partners to discuss how best to ensure access to Community Supports for eligible beneficiaries. Next steps include exploring the feasibility of contracts with tribal entities or their partnered community based to provide Community Support services. The Riverside San Bernardino Indian Health Clinic, an FQHC serving tribal health plan Members, will assess tribal Members in need of Community Support services to initiate the appropriate referrals and care coordination. Formalizing these care coordination processes and relationships into an MOU is under discussion.

or other agreements *100 word limit*	
3. Describe plan to develop provider capacity and Community Supports (ILOS) services for members *100 word limit*	The health plan has already met with tribal partners twice to make them aware of the Community Supports services. Further discussion will explore the feasibility of contracting with tribal entities and/or their partner community-based organizations to provide Community Support services. The health plan will monitor Community Supports requests/utilization by eligible tribal beneficiaries to ensure appropriate Community Supports Provider capacity. If gaps are identified, the health plan will work with the tribes and Community Supports network to enhance access to those impacted services and will allocate incentive program dollars to support capacity as necessary.

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*
Since 2020, county health plans (IEHP and Molina) have had quarterly leadership meetings and monthly workgroup meetings to coordinate CalAIM efforts. Standing agenda items include: Community Supports offerings/coordination; Community Supports infrastructure for referrals, authorizations, billing, and regulatory oversight; data-sharing agreements to support continuity of CalAIM services for beneficiaries across IEHP and Molina; alignment of ECM programs (e.g., Model of Care, assessments, reimbursement); IT svstems; and coordination of CalAIM incentive funding. These meetings will continue throughout 2022 – supporting documentation is provided with this proposal.

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*
The two county health plans (IEHP and Molina) have been collaborating since 2020 in preparation for CalAIM's launch. This work will continue through 2022 as opportunities are identified to leverage and expand on existing collaborative Health Homes Program efforts to support ECM expansion. To date, collaborative activities have included regular joint meetings with Molina, county agencies, and community-based organizations to discuss ECM. There have been discussions between IEHP and Molina regarding funding to expand ECM capacity using incentive program dollars – supporting documentation is provided with this proposal.

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*
The two county health plans (IEHP and Molina) have been collaborating since 2020 in preparation for CalAIM's launch. This work will continue through 2022 as opportunities are identified to leverage and expand on existing collaborative WPC efforts. Similarly, efforts will continue to jointly enhance Community Supports capacity. To date, collaborative activities have included regular joint meetings with Molina, county agencies, and community-based organizations to discuss Community Supports. There have been discussions between IEHP and Molina regarding jointly funding specific Community Support vendors or projects to expand capacity using incentive program dollars – supporting documentation is provided with this proposal.