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	San Francisco Health Plan
MCP County	San Francisco
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	100
3. Community Supports (ILOS) Provider Capacity Building and Community Supports (ILOS) Take-Up	Minimum of 30%	300	200
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*
For measure 1.3.4, SFHP is only be able to earn 60 points (of 80) due to offering only 2 community supports in 2022. SFHP requests to reallocate the 20 unearned points from Priority Area 3 (Community Supports Provider Capacity & Take up) to Priority Area 2 (ECM Provider Capacity Building). Allocating points to Priority Area 2 aligns with SFHP's allocation of discretionary points overall, putting a heavier weight on Priority Areas 2 and 3.

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*	SFHP will employ a multi-pronged approach to identifying 3-4 underserved populations in the County which includes the following: • SFHP Data: SFHP will utilize existing HEDIS and Population Assessment data to identify racial/ethnic health disparities affecting SFHP membership. • New Data: SFHP will incorporate California Health Places Index into core SFHP systems to identify neighborhood needs at census tract level. • Anthem Coordination: SFHP will continue to engage with and collaborate with Anthem Blue Cross via monthly meetings. • County: Collaborate with County to retrieve and share Social Determinants of Health data.
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*	All of SFHP's ECM providers launching in January are able to electronically exchange care plan and clinical documentation with care team members. SFHP will focus on supporting ECM providers to enhance their systems and recommend best practices to ensure best outcomes. Steps to be taken will include: • Develop an assessment tool to evaluate opportunities to improve information exchange amongst ECM/Care Team providers and other Community Providers. • Develop and deploy trainings on best practices for sharing care plan information. • Work in partnership with the County to develop appropriate levels of access to care plan documents through EPIC Carelink.
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	All of SFHP's ECM providers launching in January have access to and will be utilizing certified EHR technology to generate and manage a care plan. SFHP will focus on supporting ECM providers on process and system enhancements related to care plan development and management. SFHP will take the following steps: • Develop a standard template with essential data requirements

documentation system able to generate and manage a patient care plan *100 word limit*	• Survey providers to identify systems gaps and potential opportunities for SFHP to provide support in optimizing electronic data exchange and care plan development • Facilitate a learning collaborative for providers to share best practices or approaches to maximizing system functionality
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*	All of SFHP's ECM providers launching in January have the ability to submit a claim/invoice. SFHP will focus on supporting ECM providers to implement more automated claims submission processes, which may include enhancements to their own systems and/or utilizing clearinghouses for claim submissions. SFHP will take the following steps: • Work with providers to utilize clearinghouses as a method to improve accuracy of claim submissions • Develop trainings and provide technical assistance for ECM providers to submit claims/invoices to SFHP • Create claims submission oversight process to identify, monitor and address accuracy issues and provide targeted follow up to providers to improve compliance
5. Describe approaches for collaborating with, Social Services, County Behavioral Health, and County/Local Public Health Agencies within the county to improve data	SFHP will actively participate in operational/tactical and leadership/strategic meetings with key stakeholders at the County including but not limited to: • Department of Public Health (DPH) – County Behavioral Health, Jail Health, Whole Person Integrated Care, SFHN • Human Services Agency (HSA) • Department of Homelessness and Supportive Housing (HSH) • Department of Aging SFHP will take the following steps:

integration and electronic data sharing, capabilities among physical health, behavioral health and social service providers *100 word limit*	• Develop a roadmap outlining engagement activities with stakeholders • Continue engagement through existing collaborative framework established through Whole Person Care and ECM/CS implementation • Aim to develop and utilize a standardized Release of Information
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*	SFHP will continue to engage frequently and intensely with SF DPH Whole Person Care as additional Community Supports are rolled out over the next 18 months. SFHP will build on identified opportunities with WPC: • Support SF DPH in their plans to integrate WPC data infrastructure into EPIC, SF DPH's EHR, which would bolster and streamline data sharing to both County providers as well as other non-County providers. • Build upon mechanisms created under WPC that improved collaboration and information sharing with non-County clinics/CBOs providers • Leverage County & EPIC in supporting non-County providers to improve data sharing and data quality.
7. Any additional Information on Delivery System Infrastructure Gaps in County *100 word limit*	SFHP does not have any additional information to provide regarding delivery system infrastructure gaps in San Francisco.

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,	SFHP appreciates that building ECM provider capacity, especially with the expansion to new Populations of Focus (POFs), will require significant resources and a structured approach over the next several years. To address gaps and build ECM capacity, SFHP will: • Develop a work plan to assess and address ECM provider needs as well as monitor readiness to serve additional POFs. • Complete an environmental scan to identify and engage new providers, especially non-traditional providers who historically have not contracted with SFHP as a provider

of at least 20% improvement, to address gaps *100 word limit*	• Ensure new providers complete SFHP's readiness and certification process which outlines how they will build capacity over time.
2. Identify ECM workforce, training, and TA needs in county, including specific cultural competency needs by county *100 word limit*	SFHP will implement a monthly, "All ECM Provider" meeting to continuously engage with providers. On a quarterly basis, SFHP will dedicate a meeting to collate training, TA, and cultural competency needs within the provider network. Based upon the needs SFHP will develop a plan to prioritize and address the needs as identified by the providers. In addition, SFHP will continue to staff and monitor an SFHP CalAIM inbox to triage provider issues, feedback, and recommendations. Any trends in provider needs or provider recommendations will be escalated to a SFHP ECM/CS Committee to act upon.
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*	SFHP will support providers through the following methods: • Develop a tool to assess ECM providers' top barriers for recruiting and hiring necessary staff • SFHP will share recruitment best practices and tools (e.g. job descriptions, staffing models, case ratios, etc.)
4. Describe approach to develop and administer an MCP training and TA program for ECM Providers *100 word limit*	SFHP will deploy a robust training curriculum for ECM providers with trainings available throughout the calendar year. Training topics will include ECM core service components, outreach best practices, care plan development, care coordination, and referral management as well as topics that have been identified or requested from our providers. Trainings will be recorded and available online to all ECM providers. In addition, SFHP will continuously update the SFHP ECM Program Guide, which describes DHCS and SFHP requirements for ECM as well as information on data exchange, payment, and program monitoring/oversight, etc.

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*	SFHP will utilize a two-prong approach for oversight of providers to ensure they are successfully engaging with hard to reach Populations of Focus.
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*	SFHP will align across systems and entities to build ECM capacity with County agencies (HSH, HSA, SFHN, BHS) through weekly tactical meetings and monthly leadership meetings. SFHP will coordinate with County agencies on overlapping case management programs serving ECM members to identify and ensure members are served by the most appropriate program for their needs and acuity.
7. Describe approach to build, develop, or invest in the necessary behavioral health workforce to	SFHP will support building and growing the behavioral health workforce by identifying where there is overlap with ECM and working to align efforts. SFHP will collaborate and support County Behavioral Health (BHS) in their implementation of a central triage team that will help identify individuals eligible for ECM and coordinate care across the various County delivery systems, including SFHN.

support the launch of ECM *100 word limit*	

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*	
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*	
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*	

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*	SFHP has approximately 365 members who identify as American Indian/Alaskan Native, which represents about 0.23% of SFHP's total membership. SF County has 2 tribal providers: Native American Health Center (which is included in SFHP's network) and Friendship House Association. About 230 SFHP members access services at Native American Health Center. For phase I of ECM implementation, 1% of SFHP's ECM eligible population identified as AI/AN (36 members).
2. Outline a plan to establish a strategic partnership including any plans for formalization such as a MOU or other agreements *100 word limit*	SFHP will work with both tribal providers to identify SFHP members accessing services and establish referral processes and coordination, especially for members that are eligible for ECM. SFHP will engage with Friendship House Association to establish a formal MOU or data sharing agreement to facilitate the identification of SFHP members served at Friendship House and coordinating referrals, but also to explore the potential for a contractual agreement as an ECM provider.
3. Describe plan to develop provider capacity and ECM services for members *100 word limit*	SFHP will engage with both tribal providers on their readiness and capacity to provide ECM, as well as solicit feedback and suggestions on community partners that could potentially be ECM/CS providers for this population.

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*	In San Francisco (2019 data), the racial and ethnic groups who are most disproportionately experiencing homelessness are: 1) Black/African American - 37% of those experiencing homelessness, but only 6% of the SF general population 2) Multiracial – 22% of those experiencing homelessness, but only 5% of the SF general population 3) American Indian/Alaskan Native – 5% of those experiencing homelessness, but <1% of the SF general population Additionally, although not a racial/ethnic group, LGBTQ individuals are disproportionately represented in the population experiencing homelessness.
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	SFHP will work collaboratively with the Department of Homelessness and Supportive Housing (HSH), providers and community based organizations, Street Medicine, and the newly developed Office of Coordinated Care within the SF Department of Public Health to identify and deploy effective outreach strategies. SFHP will take the following actionable steps: 1) Improve data sharing to more effectively identify SFHP members experiencing homelessness 2) Establish referral & linkage strategies to ensure members experiencing homelessness are connected to Coordinated Entry for assessment and appropriate interventions

100 word limit	3) Collaborate with County agencies and CBOs to share best practices and offer training opportunities

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 top racial and ethnic groups that are incarcerated in San Francisco are: • Black (46%) • White (26%) • Latino (16%)
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*	SFHP will be closely partnering with City and County of San Francisco departments and agencies serving individuals transitioning from incarceration in order to align with existing efforts on outreach and engagement. Southeast Health Center, a primary care clinic in SFHP's network with a Transitions Clinic, has extensive experience serving this population. SFHP will engage with leadership at this clinic to learn best practices and support training, education and implementation of effective outreach and engagement methods.

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*	SFHP has identified the following limitations in Community Supports coverage in SF: 1) Administrative complexity: some organizations are hesitant to participate in CS due to concerns about their ability to support new Medi-Cal processes such as referrals, authorizations, billing and claiming, etc. 2) Physical capacity limitations: some providers willing to participate are limited in their ability to increase capacity due to the physical space they operate in – for example, limited beds available for medical respite. 3) Funding: interested providers report ongoing concerns with reimbursements and funding not being sufficient to support increases in capacity.
2. Describe the plan to increase number and/or reach of Community Supports (ILOS) offered in January 2022 or July 2022 *100 word limit*	SFHP will build upon existing Whole Person Care infrastructure and stakeholder networks to identify and outreach to interested providers for medical respite and housing navigation services, the Community Supports planned for implementation in January/July of 2022. SFHP will engage with WPC providers as well as other interested potential providers to build relationships, identify and remedy concerns to facilitate readiness and onboarding.

[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*	SFHP has identified the following gaps in provider capacity: • Medical Respite: SFHP's network is currently limited to one County-run facility, which prioritizes individuals transitioning from the County public hospital. SFHP is working with the County on plans to grow capacity at this facility as well as identifying other facilities/providers with capacity for recuperative care services, including behavioral health respite services. • Housing Community Supports: provider capacity is limited to those prioritized for Coordinated Entry. SFHP is prioritizing working with the County to grow capacity, but will continue exploring capacity with other providers able to offer these services outside of Coordinated Entry.
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*	SFHP has identified a TA need related to Medi-Cal billing processes for community supports providers, most of whom have not previously engaged with Managed Care Plans or billed services through Medi-Cal. In addition to providing direct TA and training, SFHP is also partnering with the County to leverage where their existing infrastructure (and Electronic Health Record) can support providers in the delivery and billing of community supports services. SFHP is not aware of any cultural or linguistic gaps identified through Whole Person Care, but will confirm with the County as Lead Entity.
5. Plan to develop and administer a training and TA program for Community Supports (ILOS) Providers *100 word limit*	SFHP will collaborate with Anthem and Community Supports providers to develop and administer a training and technical assistance (TA) program for existing providers as well as community-based partners who are interested in becoming Community Supports providers. SFHP will take the following steps: • Collect input from Community Supports providers on topics of interest and recommendations to inform development of an overall training and TA program. • Engage external SMEs and partners, as needed, to implement the program.

	• Collaborate with Anthem to avoid duplication and ensure cohesive county wide training and TA program.
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*	SFHP will collaborate with Community Supports providers and partners to identify workforce recruiting and hiring needs and develop a plan to address the needs identified. SFHP will take the following steps: • Develop a workforce needs assessment with Community Supports providers to identify and track gaps and needs. • Require CS providers submit staffing models and report regularly on staffing and vacancies to monitor caseloads. • Establish staffing targets for Community Supports providers tied to financial incentives.
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*	SFHP will actively participate in meetings with key stakeholders at SF DPH, including County Behavioral Health, SFHN, and other County Departments including but not limited to: • Human Services Agency • Department of Homelessness and Supportive Housing • Department of Aging SFHP will take the following steps: • Continue leveraging existing meeting infrastructure with SFDPH and HSH to collaborate, assess, prioritize and align on activities, including on DHCS funding opportunities. • Develop a County-wide roadmap to share major implementation milestones with impacted County partners and engage key stakeholders. • Partner with Anthem to align on provider education and expectations/direction to providers on building capacity.

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*	Approximately 365 SFHP members (0.23%) identify as American Indian/Alaskan Native. SFHP anticipates that AI/AN members will be eligible for medical respite and housing community supports, and that referral processes with the two tribal providers in SF County will be important for connecting these members to services. In SF County, the two tribal providers are Native American Health Center (currently in SFHP's network) and Friendship House Association (not currently in SFHP's network).
2. Outline a plan to establish a strategic partnership including any plans for formalization such as a MOU	SFHP will engage with both tribal providers to establish referral processes for SFHP members eligible for Community Supports. SFHP will engage with Friendship House Association to establish a formal MOU or data sharing agreement, with the goal of identifying opportunities to coordinate care and refer SFHP members to available Community Supports.

or other agreements *100 word limit*	
3. Describe plan to develop provider capacity and Community Supports (ILOS) services for members *100 word limit*	SFHP will engage with Native American Health Center and Friendship House Association on their readiness and capacity to provide Community Supports, as well as solicit feedback and suggestions on community partners that could be potential CS providers for this population. SFHP will pursue engagement with interested providers, either by MOU to establish referral processes or formal contracts to deliver 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*
SFHP will continue to collaborate with Anthem Blue Cross to support ECM & CS implementation and on-going monitoring activities. SFHP and Anthem will meet monthly to align on messaging (e.g. core service expectations) to shared providers, when appropriate. SFHP and Anthem will work to build parallel infrastructures for the benefit of the providers and members.

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*
SFHP and Anthem will collaborate on an approach to increase provider capacity. This will include leveraging monthly meetings to align on the pace and direction of capacity growth and expansion. SFHP and Anthem will build upon Health Home best practices and lessons learned and provide parallel messaging and expectations to shared providers. Both SFHP & Anthem will document all shared meeting agendas and minutes.

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*
SFHP meets regularly with our MCP partner, Anthem, to discuss collaboration strategies, avoid duplication of efforts and align on approaches to leverage and expand WPC capacity and county wide Community Supports capacity. SFHP will take the following steps: • Enter into an MOU with Anthem, outlining a plan for collaboration to support capacity building approaches for Community Supports in SF County. • Develop tools to assess member needs and provider capacity. • Ensure alignment on measuring and monitoring capacity growth • Develop a roadmap for Community Supports provider onboarding and continuous capacity building support. • Alignment on implementation timeline and messaging to providers