ENHANCED CARE MANAGEMENT

QUALITY IMPROVEMENT PROGRAM

DETAILED SPECIFICATIONS

2022

MEASUREMENT YEAR

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I. PHC Program Contact Information

Email for reporting: ECM@partnershiphp.org

Email for payment: ECMQIP@partnershiphp.org

II. Program Overview & Background

Enhanced Care Management (ECM) Quality Improvement Program (QIP) is a Medi-Cal benefit that replaces the current Whole Person Care (WPC) Pilot and Intensive Outpatient Care Management (IOPCM) activities. Part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the objective of ECM is to motivate, modify, and improve the health outcomes of seven (7) identified groups of individuals by standardizing a set of care management services and interventions, and then building upon the positive outcomes from those programs. CalAIM is a multi-year initiative, organized by the Department of Health Care Services (DHCS) for the purpose of addressing the multifaceted challenges facing California's most vulnerable residents.

The seven (7) identified groups of individuals or Populations of Focus include:

Phase I: Starting January 1, 2022
(Phase I counties only – see Go-Live Schedule in Eligibility Criteria section):

1. Adult individuals experiencing homelessness (as defined by HUD), AND who have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and decreased utilization of high high-cost services.
2. Adult High Utilizer individuals with five (5) or more emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence; AND/OR three (3) or more unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.
3. Adult individuals with SMH or SUD who meet with eligibility criteria for participating in the County Specialty Mental Health (SMH) Plans and/or the Drug Medi-Cal Organization Delivery System (DMC-ODS) AND who are actively experiencing at least one (1) complex social factor influencing their health AND who meet one (1) or more criteria as follows:
    - are at high risk for institutionalization, overdose and/or suicide;
    - Use crisis services, emergency rooms, urgent care or inpatient stays as the sole source of care;
    - experienced two or more ED visits or two or more hospitalizations due to SMI or SUD in the past 12 months; or
    - are pregnant or post-partum women (12 months from delivery).

Phase II: Starting July 1, 2022
(Phase II counties only – see Go-Live Schedule in Eligibility Criteria section):
Same populations of focus as above.

Phase III: Starting January 1, 2023 (ALL counties):

4. Individuals at risk for institutionalization who are eligible for long-term care services.
5. Nursing facility residents who want to transition to the community.

Phase IV: Starting in July 2023 (ALL counties):

6. Children or youth with complex physical, behavioral or developmental health needs (ex: CCS, foster care, youth with Clinical Risk Syndrome, or first episode of psychosis).
7. The Incarcerated and Transitioning to the Community Population of Focus will go live statewide in alignment with pre-release Medi-Cal services. DHCS will announce timing at a later date in alignment with the 1115 demonstration waiver request to provide pre-release services in the 90 days prior to release.

Guiding Principles

The ECM QIP adheres to the three guiding principles of the DHCS CalAIM program.

1. Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

Eligibility Criteria

The ECM QIP is available to contracted provider sites within the 14 counties PHC serves. While services are available to the 14 counties, not all counties are eligible to contract with PHC as of January 1, 2022. The schedule for ECM service availability will be initiated in two (2) primary phases. The go-live schedule for Phase I and Phase II is as follows:

- Phase I – existing Whole Person Care Programs that will transition to the new ECM benefit
- Phase II – counties without existing Whole Person Care Programs

Go-Live Schedule

Phase I: January 1, 2022	Phase II: July 1, 2022		Phase III: January 1, 2023	Phase IV: July 1, 2023
Marin	Solano	Trinity	All 14 Counties	All 14 Counties
Napa	Lake	Siskiyou		
Mendocino	Yolo	Modoc		
Shasta	Humboldt	Lassen		
Sonoma	Del Norte			

Program specifications are in effect for the time reporting period of January 1, 2022, through December 31, 2022. Specifications are subject to change based on DHCS and PHC direction and notification of changes will be made to all participating providers via the Quality Incentive Program (QIP) team.

Participation Requirements

All contracted ECM provider sites will be automatically enrolled in the CalAIM Reporting Incentive Program and therefore eligible for CalAIM Reporting Incentive payments. The incentive program is monitored by the ECM QIP team. Provider sites must be in good standing with the state and federal regulators as of the month the payment is to be distributed. Good standing is defined as:

1. Provider is open for services to PHC members.
2. Provider is financially solvent (not in bankruptcy proceedings).
3. Provider is not under financial or administrative sanctions, exclusion or disbarment from the State of California, including the Department of Health Care Services (DHCS) or the federal government including the Centers for Medicare & Medicaid Services (CMS). If a provider appeals a sanction and prevails, PHC will consider a request to change the provider status to good standing.
4. Provider is not pursuing any litigation or arbitration against PHC.
5. Provider has not issued or threatened to issue a contract termination notice, and any contract renewal negotiations are not prolonged.
6. Provider has demonstrated the intent to work with PHC on addressing community and member issues.
7. Provider is adhering to the terms of their contract (including following PHC policies, quality, encounter data completeness, and billing timeliness requirements).
8. Provider is not under investigation for fraud, embezzlement or overbilling.
9. Provider is not conducting other activities adverse to the business interests of PHC.

In addition, PHC has the sole authority to further determine if a provider is in Good Standing based on the criteria set forth above.

Payment

Payment Schedule

Calculations for payment will be done on a monthly basis, defined as a calendar month, but paid out quarterly. Providers can expect to receive payment for the previous quarter up to 60 days after the close of the final month of the quarter. Please refer to the below Payment Schedule.

Reporting Period	Payment Month
January - March 2022	May 2022
April - June 2022	August 2022
July - September 2022	November 2022
October - December 2022	February 2023

Payment Methodology

The rate for payment will be $100 PMPM. This means for every enrolled ECM member the ECM provider will receive $100 for submission of all required reports from that particular month. All reporting will be paid based on timeliness of submission. Timeliness is defined as submitting reports to PHC on-time as defined in the above Reporting Timeline (below). Payment will be calculated utilizing the below methodology.

- Submissions are considered complete and will be paid at 100% if all three (3) of the reporting requirements are submitted on or before their due date.
- Any submission(s) that are received up to one (1) week or five (5) business days past the due date will be paid at 50%.
- Any submission(s) that are not received within the five (5) business days will be considered late and will be paid at 0%.
- Any report that is more than thirty (30) days overdue will initiate a corrective action which can include separation from participation in the ECM program as a provider.

Example:

A provider has 50 enrolled ECM members and submits all three (3) reports on or before the due date for all three months of the quarter. Payment for the entire quarter would be $15,000 or $5,000 for each month. Please note that enrollment may fluctuate from month to month which will impact the calculation.

There may be opportunity for additional payments once the program year has been completed and an assessment has been made of fund balance. Additional payments are at the discretion of the plan and are not guaranteed.

Subsequent Program Years

It is understood that program years 2 and 3 will likely focus on quality outcomes and incentive payments will be tied to performance and/or improvement to current health outcomes and metrics.

Reporting

Reporting Requirements

Reports for Return Transmission File (RTF), Initial Outreach Tracker File (IOT), and Provider Capacity Survey are required to be submitted on a monthly basis by all ECM providers.

Reporting template links can be accessed in the Reporting Timeline and Template table below. Please note, the Provider Capacity Survey will be made available to providers via Google Docs, or another form of communication agreed upon by PHC and ECM provider. No template link is provided for this document in the Reporting Timeline below.

For any Collective Medical issues, please reach out to: support@collectivemedical.com.

For issues or questions related to the reporting templates, submissions via the sFTP folders, please reach out to: ECM@partnershiphp.org. Partnership will assist with any troubleshooting issues that may arise.

Reporting Timeline & Templates

MY 2022 ECM QIP Reporting Timeline & Templates		
Report Name / Submission Pathway / Naming Convention	**Reporting Schedule / Due Dates ***	**Responsible Party / Submission Template Link**
Report Name: ECM Provider Return Transmission File **(RTF)** **Submission Pathway:** sFTP **Naming Convention:** *Facility Name_RTF_Date*	**2nd Friday of the month:** 02/11/2022; 03/11/2022; 04/08/2022; 05/13/2022; 06/10/2022; 07/15/2022; 08/12/2022; 09/16/2022; 10/14/2022; 11/11/2022; 12/16/2022	**Provider** *(File sent via sFTP Folders)* **Link to Submission Template** Provider Return Transmission File (RTF)
Report Name: ECM Provider Initial Outreach Tracker File **(IOT)** **Submission Pathway:** sFTP **Naming Convention**: *Facility Name_IOT_Date*	**2nd Friday of the month:** 02/11/2022; 03/11/2022; 04/08/2022; 05/13/2022; 06/10/2022; 07/15/2022; 08/12/2022; 09/16/2022; 10/14/2022; 11/11/2022; 12/16/2022	**Provider** *(File sent via sFTP Folders)* **Link to Submission Template** Provider Initial Outreach Tracker File (IOT)
Report Name: Provider Capacity Survey **Submission Pathway:** Google Docs	**4th Tuesday of the month**: 02/22/2022; 03/22/2022; 04/26/2022; 05/24/2022; 06/28/2022; 07/26/2022; 08/23/2022; 09/27/2022; 10/25/2022; 11/22/2022; 12/27/2022	**Provider** *(Survey sent via Google Forms)*

* The above-mentioned Reporting Schedule and Due Dates are subject to change based upon necessary timeframes needed for file completion.

Example:

PHC sends files to providers on July 1st to complete and return to PHC by the *second week* of the month. This due date would technically be July 8th, because of the July 4th holiday, and would only allow four (4) days for providers to return the completed files to PHC. Therefore, it was necessary to extend the due date to July 15th to allow adequate time for providers to complete and the return the files to PHC.