ENHANCED CARE MANAGEMENT

QUALITY IMPROVEMENT PROGRAM

DETAILED SPECIFICATIONS

2024 MEASUREMENT YEAR

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PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ACCREDITED NCQA HEALTH PLAN

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I. PHC Program Contact Information

ECM QIP Team: ECMQIP@partnershiphp.org

II. Program Overview & Background

Enhanced Care Management (ECM) Quality Improvement Program (QIP) is a Medi-Cal benefit that replaced the previous Whole Person Care (WPC) Pilot and Intensive Outpatient Care Management (IOPCM) activities. As 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 ten (10) identified groups 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.

Program specifications are in effect for the measurement year of January 1, 2024 through December 31, 2024. Specifications are subject to change based on DHCS and PHC direction, and notification of changes will be made to all participating providers via the ECM QIP Team.

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 counties PHC serves.

Participation Requirements

1. All contracted ECM provider sites will be automatically enrolled in the CalAIM Reporting Incentive Program and, therefore, are eligible for CalAIM Reporting Incentive payments. The incentive program is managed 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: 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 Methodology

Participating ECM providers are evaluated based on the gateway measure and its incentive pool amount. The gateway measure determines the number of dollars available for the remaining reporting measures in the program. Providers have an opportunity to earn a percentage of the allotted incentive pool based on full or partial credit, with the potential to earn 100% of their allocated incentive dollars available in the pool.

The incentive rate is $100 per member per month (PMPM). This means for every enrolled ECM member, $100 will be placed in the incentive pool. There are two components to the gateway measure providers required to earn incentive pool dollars: Timely Reporting and Report Accuracy.

Timely Reporting

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

Example:

– In October, a provider submits timely reports for 50 enrolled ECM members. A total of $5,000 will be held in the incentive pool.

Incentive Pool Allotment: Providers can earn a percentage of the allotted incentive pool money if they meet one (1) or more of three (3) reporting measures:

- Measure 1: up to 30% of total incentive pool
- Measure 2: up to 35% of total incentive pool
- Measure 3: up to 35% of total incentive pool

Example:

- The provider has 10 patients and submits timely reports for three (3) months in a quarter: 10 patients x $100 (PMPM) x three (3) months = $3,000 placed in the incentive pool
- If the provider meets Measures 2 and 3 with full credit, but did not meet Measure 1, they would earn 70% (35% for Measure 2 + 35% for Measure = 70%) x $3,000 = $2,100 incentive payment for the quarterly reporting period.

Payment Data

PHC receives member enrollment data from the provider-required DHCS report (ECM Provider Return Transmission File - RTF) and other internal data sources that capture Treatment Authorization Requests (TAR) to validate member enrollment during the reporting period. PHC's ECM Team retrieves and sorts this data based on the **TAR request date** and calculates the total enrolled member count for the reporting period. This information is provided to the ECM QIP Team for measure scoring and incentive payment calculation.

Retroactive (retro) TARs: PHC defines a retro TAR as an authorization request submitted after the authorization start date that covers services already performed. In order to capture the most accurate member enrollment counts, not every retro TAR may fall under the grace period.

Example: TAR requested by provider on 1/15/2024 for services starting 12/25/2023

PHC's ECM Team is aware providers may need to submit retro TARs and will incorporate as many retro TARs as possible that were submitted after the reporting month if they are submitted within a reasonable timeframe. PHC will allow requests submitted up to one (1) calendar month after the reporting month to be calculated in the denominator for incentive payments. Providers are encouraged to add enrolled members to the reporting files and submit TARs as soon as possible to meet the cut-off times defined by the ECM QIP.

Payment Schedule

Incentive payment calculation and distribution is completed on a quarterly basis. Providers can expect to receive payment 90 days after the close of each quarterly reporting period. Please refer to the Payment Schedule below.

Reporting Period	Payment Distribution
January - March 2023	June 2023
April - June 2023	September 2023
July - September 2023	December 2023
October - December 2023	March 2024

Payment Dispute Policy

ECM QIP participants are provided a preliminary payment report which outlines final results for all measures before final payment is distributed. Providers are given a one-week period and are strongly encouraged to review their preliminary payment report for discrepancies. Beyond this review period, disputes will not be considered. If, during the Preliminary Report review period, a provider does not inform PHC of a potential discrepancy that might result in under or over payment, the error may be corrected post-payment through a formal appeal process. Additionally, PHC may recoup overpayments any time after payment is distributed.

The formal appeal process is offered for up to 30 days after the ECM provider has received their final payment statement. A Payment Dispute Form must be completed within the same 30 days of receiving the final statement. Please reach out to the ECM QIP team for a Payment Dispute Form at: ECMQIP@partnershiphp.org. All payment adjustments will require review and approval by PHC's Executive Team.

Reporting Requirements

Please review the Submission Timeline below for required report information, deadlines and reporting links.

Measures	Submission Deadlines*	Links & Submission Information
Gateway Measure		
ECM Provider Return Transmission File (RTF) **Naming Convention:** *Facility Name_RTF_Date*	**DUE MONTHLY** ECM Team will provide specific date	**Link:** Provider Return Transmission File (RTF) **Provider** submits RTF via sFTP folders
ECM Provider Initial Outreach Tracker File (IOT) **Naming Convention:** *Facility Name_IOT_Date*	**DUE MONTHLY** ECM Team will provide specific date	**Link:** Provider Initial Outreach Tracker File (IOT) **Provider** submits IOT via sFTP folders
Provider Capacity Survey	**DUE MONTHLY** ECM Team will provide specific date	**Provider** submits survey via Google Docs (or another form of communication agreed upon by PHC and ECM provider).
Measure 1		
Care Plan and ROI upload into PointClickCare	**UPLOAD WITHIN 60 DAYS** of TAR request date or TAR renewal request date	**Document Requrements:** ECM Care Plan form Release of Information (ROI) form
Measure 2		
PHQ-9 Depression Screening **Naming Convention:** *Facility Name_PHQ9_Date*	**DUE QUARTERLY** by the **2nd Friday** of the month following end of quarterly reporting period	**Link:** PHQ-9 Depression Screening & Blood Pressure Screening Template **Provider** submits template via sFTP folders NOTE: Depression & Blood Pressure screenings should be submitted using one template.
Measure 3		
CBP Blood Pressure Screening **Naming Convention:** *Facility Name_CBP_Date*	**DUE QUARTERLY** by the **2nd Friday** of the month following end of quarterly reporting period	**Link:** PHQ-9 Depression Screening & Blood Pressure Screening Template **Provider** submits template via sFTP folders NOTE: Depression & Blood Pressure screenings should be submitted using one template.

* Deadlines are subjct to change based upon necessary timeframes needed for file completion. PHC will notify providers via mail of any date changes. Please contact PHC's ECM Team at ECM@partnershiphp.org for any questions for specific RTF, IOT and Provider Capacity Survey due dates.

III. Gateway Measure: Timely Reporting

Description

The gateway measure determines the number of dollars available for the remaining three measures. 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 in order to participate in the other three measures of this program.

Measurement Period

January 1, 2024 – December 31, 2024

Quarterly reporting period: January-March , April-June, July-September, October-December

Measurement and payment takes place quarterly throughout the entire measurement year. Please refer to the Payment Schedule on page 4.

Reporting Guidelines

Reporting template links can be accessed in the Reporting Timeline and Template table below.

Measure	Submission Deadline	Submission Links & Information
ECM Provider Return Transmission File (RTF) **Naming Convention:** *Facility Name_RTF_Date*	**DUE MONTHLY** ECM Team will provide specific date	**Link:** Provider Return Transmission File (RTF) **Provider** submits RTF via sFTP folders
ECM Provider Initial Outreach Tracker File (IOT) **Naming Convention:** *Facility Name_IOT_Date*	**DUE MONTHLY** ECM Team will provide specific date	**Link:** Provider Initial Outreach Tracker File (IOT) **Provider** submits IOT via sFTP folders
Provider Capacity Survey	**DUE MONTHLY** ECM Team will provide specific date	**Provider** submits survey via Google Docs (or another form of communication agreed upon by PHC and ECM provider

* Deadlines are subject to change based upon necessary timeframes needed for file completion. PHC will notify providers via email of any date changes. Please contact PHC's ECM Team at ECM@partnershiphp.org for any questions about specific RTF, IOT and Provider Capacity Survey due dates.

IV. Reporting Measures

Measure 1. Care Plan and ROI Form Submission into PointClickCare

Description

As a requirement of the contract, for all ECM enrolled members, providers need to upload a Care Plan and Release of Information (ROI) into PointClickCare within **60 days of the TAR request date**. Additionally, for each TAR renewal, Care Plans and ROI forms must be uploaded into PointClickCare within **60 days of the TAR renewal request date.**

PHC ROI forms and DHCS ROI forms have a 5-year expiration, unless indicated by the member to end earlier, and only need to be uploaded into PointClickCare when the member is newly enrolled (first TAR request date). Providers may use their own ECM-specific ROI form; however, this provider's ROI form must be uploaded in PointClickCare within 60 days of the TAR authorized request date AND TAR renewal authorized request date.

Measurement Period

January 1, 2024 – December 31, 2024

Quarterly reporting period: January-March , April-June, July-September, October-December

Measurement and payment takes place quarterly throughout the entire measurement year. Please refer to the Payment Schedule on page 4.

Thresholds

Eligible Incentive: 30% of total incentive pool

Targets:

- Full credit: ≥ 80% of Care Plans and ROI forms entered in PointClickCare
- Partial credit: 70 - 79% of Care Plans and ROI forms entered in PointClickCare

Denominator

ECM members enrolled in one or more of the ECM Populations of Focus

Numerator

ECM members enrolled in one or more of the ECM Populations of Focus whose Care Plans and ROI forms are uploaded in PointClickCare within 60 days of the current TAR request date

Exclusions

Members not found in PointClickCare

Reporting Guidelines

Providers must upload Care Plans and ROI forms into PointClickCare **within 60 days of the TAR request date and TAR renewal request date**. PHC will audit PointClickCare for evidence of Care Plans and ROI forms uploaded into PointClickCare within the required timeframe.

Reporting Information & Deadline		
Care Plan and Release of Information (ROI) forms submission into PointClickCare	**UPLOAD WITHIN 60 DAYS** of TAR request date or TAR renewal request date	**Links:** ECM Care Plan form Release of Information (ROI) form

Measure 2. PHQ-9 Depression Screening

Description

Depression screening using the Patient Health Questionnaire-9 (PHQ-9) needs to be completed for all ECM enrolled members, 12 years of age or older, as part of the initial assessment and development of the Care Plan. Depression screening must be completed annually at a minimum.

Depression screening scores from previous quarters can be used in the 2024 measurement period if score was captured within 12 months of reporting period **and** the previous score was normal. However**,** if the previous score was 15 or higher, providers must complete the screening every quarter until the result is normal.

Providers may use the Patient Health Questionnaire-2 (PHQ-2) to complete a screening; however, if the PHQ-2 score is three (3) points or higher, the provider must complete the screening again using the PHQ-9.

Members with Intellectual/Developmental Disabilities
Because it is important to screen all members for depression, the following two depression screening tool are options for screening members with intellectual and/or development disabilities.

Tool	Positive Finding
Geriatric Depression Scale Short Form (GDS)	Total Score ≥5
Patient Health Questionnaire (PHQ-9) (OV) (Observational Version)®	Total Score ≥10

The **Geriatric Depression Scale Short Form (GDS)** is recommended as a first choice. If the member cannot respond to the GDS screening, it is recommended to use the **PHQ-9 Observation Version (OV).** In this version, the questions are answered by a caregiver, nurse or someone who interacts with the member on a frequent basis. If this version is used, it can be coded like the PHQ-9.

NOTE: These tool options are for use with screening the above-mentioned Partnership members only. All other members must continue to be screened using the PHQ-9 or PHQ-2 depression screening tools. If you encounter problems with with screening a member for depression which does not fall into this category, please reach out to the ECM QIP Team.

Measurement Period

January 1, 2024 – December 31, 2024

Quarterly reporting period: January-March , April-June, July-September, October-December

Measurement and payment takes place quarterly throughout the entire measurement year. Please refer to the Payment Schedule on page 4.

Thresholds

Eligible Incentive: 35% of total incentive pool

Targets:

- Full credit: ≥ 90% of submitted and approved depression screenings
- Partial credit: 80 - 89% of submitted and approved depression screenings

Denominator

ECM members, 12 years of age or older, enrolled in one or more of the ECM Populations of Focus

Numerator

ECM members, 12 years of age or older, enrolled in one or more of the ECM Populations of Focus, and who were appropriately screened for depression

Exclusions

11 years of age and younger

Reporting Guidelines

ECM providers must complete all columns of the PHQ-9 Depression Screening & Blood Pressure Screening Template, including the provider's site name and PHC Provider ID, as well as the member's name, CIN, date of birth, and the most recent PHQ-9 depression screening date and score. The templates must be submitted through the sFTP folder.

If the PHQ-2, PHQ-9(OV) or GDS screening tool was used, please note this in the "Score" column (next to the score) on the template.

Reporting Information & Deadline		
PHQ-9 Depression Screening **Naming Convention:** *Facility Name_PHQ9_Date*	**DUE QUARTERLY** by the **2nd Friday** of the month following end of quarterly reporting period	**Link:** PHQ-9 Depression Screening & Blood Pressure Screening Template **Provider** submits template via sFTP folders

Measure 3. Controlling Blood Pressure (CBP) - Blood Pressure Screening

Description

Blood pressure screening needs to be completed for members enrolled in ECM who are 18 years of age or older (regardless of prior diagnosis of hypertension). Screening must be by an in-person visit by ECM provider staff, a clinic visit, or patient use of PHC approved home blood pressure kit. Blood pressure screening results must be documented in the case management record for potential audit.

Blood pressure screening results from previous quarters can be used in the 2024 measurement period if captured within 12 months of the reporting period **and** the previous result was normal. Normal blood pressure is either SBP < (less than) 140 or DBP < (less than) 90. If the previous result was either SBP ≥ (equal to or greater than) 140 or DBP ≥ (equal to or greater than) 90, providers must complete the screening every quarter until the result is normal.

Measurement Period

January 1, 2024 – December 31, 2024

Quarterly reporting period: January-March , April-June, July-September, October-December

Measurement and payment takes place quarterly throughout the entire measurement year. Please refer to the Payment Schedule on page 4.

Thresholds

Eligible Incentive: 35% of total incentive pool

Targets:

- Full credit: ≥ 80% of submitted and approved blood pressure screenings
- Partial credit: 70% - 79% of submitted and approved blood pressure screenings

Denominator

ECM members, 18 years of age and older, enrolled in one or more of the ECM Populations of Focus

Numerator

ECM members, 18 years of age and older, enrolled in one or more of the ECM Populations of Focus, and who were appropriately screened for blood pressure

Exclusions

17 years of age and younger

Reporting Guidelines

ECM providers must complete all columns of the PHQ-9 Depression Screening & Blood Pressure Screening Template, including the provider's site name and NPI number, as well as the member's name, CIN, date of birth, and the most recent blood pressure screening date and reading. This template must be submitted through the sFTP folder.

Reporting Information & Deadline		
CBP Blood Pressure Screening **Naming Convention:** *Facility Name_CBP_Date*	**DUE QUARTERLY** by the **2nd Friday** of the month following end of quarterly reporting period	**Link:** PHQ-9 Depression Screening & Blood Pressure Screening Template **Provider** submits template via sFTP folders

V. Appendix

Appendix I. Sample - PHQ-9 Depression Screening & Blood Pressure Screening Template

2024 ECM QIP PHQ-9 Depression Screening and Blood Pressure Screening Submission Template *(Revised 3/25/2024)*

Measurement Period: **January 1, 2024 - December 31, 2024**

Submission Frequency: **Quarterly** Submission Deadline: **2nd Friday of month following end of quarterly reporting period**

Submission Method: **sFTP Folder** Submission Naming Convention: **Facility Name_Dep-BP_Month-Year**

All information must be entered for each member. Incentive dollars will not be awarded for incomplete entries. ** Enter PHQ-2, PHQ-9(OV), or GDS tool in "Score" column*

Provider Site Name	NPI Number	Patient Name	CIN	DOB	PHQ-9 Depression Screening		Blood Pressure Screening	
					Screening Date	* Score	Screening Date	Reading