ENHANCED CARE MANAGEMENT

QUALITY IMPROVEMENT PROGRAM

DETAILED SPECIFICATIONS

2023 MEASUREMENT YEAR

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ACCREDITED NCQA HEALTH PLAN

Table of Contents

I. PHC Program Contact Information

ECM QIP Team: ECMQIP@partnershiphp.org

CalAIM/ECM Team: ECM@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: Completed January 1, 2022 (selected counties)
Phase II: Completed July 1, 2022 (selected counties)
(Refer to Go-Live Schedule on page 4 for specific counties)

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

4. PAUSED 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. PAUSED 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. The following Go-Live schedule shows the first two primary phases that were initiated in 2022, and the remaining two phases to be initiated in 2023.

Go-Live Schedule

Phase I: Completed January 1, 2022	Phase II: Completed July 1, 2022		Phase III: Starting January 1, 2023	Phase IV: Starting 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, 2023, through December 31, 2023. 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 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 based on the following submission deadlines.

- 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) that are received up to one (1) week or five (5) business days past the due date will accrue at 50%.
- Any submission(s) that are not received within the five (5) business days will be considered late and will not be eligible for incentive dollars.
- 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:

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

Providers can earn a percentage of the allotted incentive pool money if they meet one or more of three 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 inventive pool

Example:

- The provider has 10 patients and submits timely reports for 3 months in a quarter: 10 patients x $100 (PMPM) x 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 and 35% for Measure 3) x $3,000 = $2,100 incentive payment for the quarter.

Payment Schedule

Calculations for payment are completed 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 Payment Schedule below.

Reporting Period	Payment Month
January - March 2023	May 2023
April - June 2023	August 2023
July - September 2023	November 2023
October - December 2023	February 2024

Payment Dispute Policy

ECM QIP participants will be provided a preliminary payment report which outlines final results for all measures before final payment is distributed. Providers will be given a one-week period to review the 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 discrepancy that would result in potential under or over payment, the error may be corrected by PHC post-payment.

Subsequent Program Years

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

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** 2nd Friday of the month	**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** 2nd Friday of the month	**Link:** Provider Initial Outreach Tracker File (IOT) **Provider** submits IOT via sFTP folders

Provider Capacity Survey	**DUE MONTHLY** 2nd Monday of the month	**Provider** submits survey via Google Docs (or another form of communication agreed upon by PHC and ECM provider).
Measure 1		
Care Plan and Shared Consent form submission into Collective Medical	**DUE MONTHLY** 60 days of enrollment	**Links:** ECM Care Plan form Shared Consent form
Measure 2		
PHQ-9 Depression Screening **Naming Convention:** *Facility Name_PHQ9_Date*	**DUE QUARTERLY** 2nd week of the month following the end of the quarter	**Link:** PHQ-9 Depression Screening & Blood Pressure Screening Template **Provider** submits template via sFTP folders
Measure 3		
CBP Blood Pressure Screening **Naming Convention:** *Facility Name_CBP_Date*	**DUE QUARTERLY** 2nd week of the month following the end of the quarter	**Link:** PHQ-9 Depression Screening & Blood Pressure Screening Template **Provider** submits template via sFTP folders

* Deadlines 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 is necessary to extend the due date to July 15th to allow adequate time for providers to complete and the return the files to PHC. PHC will notify providers via email of any date changes. Please contact PHC's ECM Team at ECM@partnershiphp.org for specific due dates or questions.

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, 2023 – December 31, 2023

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** 2nd Friday of the month	**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** 2nd Friday of the month	**Link:** Provider Initial Outreach Tracker File (IOT) **Provider** submits IOT via sFTP folders
Provider Capacity Survey	**DUE MONTHLY** 2nd Monday of the month	**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. 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 is necessary to extend the due date to July 15th to allow adequate time for providers to complete and the return the files to PHC. PHC will notify providers via email of any date changes. Please contact PHC's ECM Team at ECM@partnershiphp.org for specific due dates or questions.

IV. Reporting Measures

Measure 1. Care Plan and Shared Consent Form Submission into Collective Medical

Description

As a requirement of the contract, for all ECM enrolled members, providers need to enter a Care Plan and Shared Consent form into Collective Medical within **60 days of enrollment.**

Measurement Period

January 1, 2023 – December 31, 2023

Thresholds

Eligible Incentive: 30% of total incentive pool

Targets:

- Full credit: ≥ 80% of Care Plans and Shared Consent forms entered in Collective Medical
- Partial credit: 70 - 79% of Care Plans and Shared Consent forms entered in Collective Medical

Denominator

The number of ECM enrolled members within 60 days of enrollment into Collective Medical.

Numerator

The number of ECM enrolled members with Care Plans and Shared Consent forms successfully entered in Collective Medical.

Reporting Guidelines

Provider must enter Care Plans and Shared Consent forms into Collective Medical within 30 days of enrollment. No submission to PHC is required. PHC will audit Collective Medical for evidence of Care Plans and Shared Consent forms in Collective Medical.

Reporting Information & Deadline		
Care Plan and Shared Consent form submission into Collective Medical	**DUE MONTHLY** 60 days of enrollment	**Links:** ECM Care Plan form Shared Consent form

See Appendix I & Appendix II to view sample forms.

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 as part of initial assessment and development of the Care Plan. All PHQ-9 depression screening must be between January 1, 2023 and December 31, 2023.

Measurement Period

January 1, 2023 – December 31, 2023

Thresholds

Eligible Incentive: 35% of total incentive pool

Targets:

- Full credit: ≥ 90%
- Partial credit: 80 - 89%

Denominator

The number of ECM enrolled members within the eligible ECM populations of focus (refer to Phases I & II).

Numerator

The number of ECM enrolled members within the eligible ECM populations of focus who were appropriately screened for depression.

Reporting Guidelines

Provider will submit the member's name, PHQ-9 screening date, score of the most recent screening, and other pertinent information using the PHQ-9 Depression Screening & Blood Pressure Screening Template.

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

See Appendix III to view the sample template.

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

Description

Blood pressure screening needs to be completed for ECM enrolled members (regardless of prior diagnosis of hypertension). Screening must be by an in-person visit by ECM 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. All blood pressures reported must be between January 1, 2023 and December 31, 2023.

Measurement Period

January 1, 2023 – December 31, 2023

Thresholds

Eligible Incentive: 35% of total incentive pool

Targets:

- Full: ≥ 80%
- Partial: 70% - 79%

Denominator

The number of assigned ECM members in the eligible ECM populations of focus (refer to Phases I and II).

Numerator

The percentage of ECM enrolled members within the eligible ECM population of focus who were appropriately screened for blood pressure.

Reporting Guidelines

ECM providers must submit the member's name, blood pressure screening date, score of the most recent screening, and other pertinent information using the PHQ-9 Depression Screening & Blood Pressure Screening Template.

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

See Appendix III to view the sample template.

V. Appendices

Appendix I. Sample Care Plan Form

PARTNERSHIP HEALTHPLAN of CALIFORNIA

ECM Care Plan Guide Date:

Patient Information			
First Name:		Last Name:	
DOB:	Sex:	Pronouns:	Primary Language:
Address Information			
Street:			
City:	State:	Zipcode:	County:
Mailing Address Same as Home Address:		____ Yes	____ No
Street:			PO Box:
City:	State:	Zipcode:	County:
Contact Information			
Email:			
Phone #:			
Phone #:			
Other Contacts			
Family/Caregiver	Name:		
Email:		Phone #:	
May we contact if needed?			
Community Team	Name:		
Email:		Phone #:	
May we contact if needed?			
Program Representative	Name:		
Email:		Phone #:	
May we contact if needed?			
Insurance Information			
Medi-Cal ID:			
Primary Insurance	Plan:		Group #:
Policy #:		Member ID:	
Secondary Insurance	Plan:		Group #:
Policy #:		Member ID:	

Acuity	Social Determinants of Health
____High Risk ___Low Risk	Education:
	Employment Status:
	Income Status:
Self-Management Assessment	Food Security:
___Poor ____Moderate ___Good	Housing Stability:
	Transportation:
	Support Networks:

ECM Criteria (Select all that apply)	
___Nursing Home Transition to the Community	___Homeless
___Specialty Mental Health	___High Utilizer
___Children/Youth with Complex Medical/Behavioral/Development Needs	___Incarceration
___At Risk of Institutionalization	___Substance Use Disorder
___Other:_____	

Physical Health

Active Medical Problems (dental health, fall risk, speech, etc.)	Past Medical History
Blood Pressure: ____Systolic / ____Diastolic	A1C Levels: _____A1C% _____mg/dl

Medication List	Indication	Allergies	Symptoms

Hospitalizations

Admissions in the last 6 mos:	Emergency Dept. visits in the last 6 mos:

Durable Medical Equipment

	Other
___Hospital Bed	
___Wheelchair	
___Walker	
___Oxygen	

Physician Visits

Primary Care Physician visits in the last 6 mos:	Last Visit Date:
Physician's Name:	Physician's Office:
Specialist visits in the last 6 mos:	Last Visit Date:
Specialist's Name:	Specialist's Office:

Mental Health History	
	PHQ-2 Score
	PHQ-9 Score

If prescribed Antidepressants or Psychotherapy, please provide more information below (E.g.: adherence to medication regimen; improvements in mental health after therapy)

Substance Use Disorder Screening	
Alcohol Use	**Drug Use**
Frequency:	Frequency Drug Type
AUDIT-C Score	DAST-10 Score

If other information requires further disclosure, please provide below:

Long-Term Support Services	
Community Based Adult Services (CBAS)	Service Name
Multi-purpose Senior Services Program (MSSP)	Service Name
Home Health Agency	Service Name
Palliative Care	Service Name
Hospice Care	Service Name
In-Home Support Services (IHSS)	Hours per month

Advanced Care Planning			
Surrogate Decision Maker	___Has One	___Needs One	___Does Not Want One
Living Will	___Has One	___Needs One	___Does Not Want One
Advance Directive	___Has One	___Needs One	___Does Not Want One
POLST	___Has One	___Needs One	___Does Not Want One
Power of Attorney	___Has One	___Needs One	___Does Not Want One
Code Status	___DNR	___Full Code	___Limited Interventions

Goals	
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Referrals Needed	

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ENHANCED CARE MANAGEMENT (ECM) SERVICES

Authorization for Use, Exchange and/or Disclosure
of My Confidential Health Care and Personal Information

PURPOSE
Health care providers, health payers, and social services agencies have joined together to provide services under the **ECM benefit** to help you get the services you may need to promote your health and well-being. To allow Partnership HealthPlan of California (PHC), and/or other participating entities to share your health care and other personal information with each other, you must first give your authorization (permission). By completing this form, you are authorizing the use and disclosure (release) of your health care and other personal information by the entities participating in ECM. The participating entities will only use and share the information necessary to achieve the intended purpose or referral. The information may be shared in a secure electronic format, in writing, or verbally during meetings to coordinate services for you. Please complete this form and send it to:

Partnership HealthPlan of California
Attn: Care Coordination – Northern Region
3688 Avtech Pkwy
Redding, CA 96002
Fax: (530) 351 -9040

OR

Partnership HealthPlan of California
Attn: Care Coordination – Southern Region
4665 Business Center Drive
Fairfield, CA 94534
Fax: (530) 351-9040

Member Information	
First Name:	Last Name:
Address:	
Phone Number:( )	Date of Birth:
Member ID/CIN:	

I authorize and request (ask) **Partnership HealthPlan of California and participating ECM entities named in Attachment A** to use and share any of my health care or other personal information with each other for the purpose stated above.

Choose ONE of the following two options:

INITIAL HERE	**Consent for communication by ECM Program:** By initialing here, I am allowing ALL of the agencies listed in ATTACHMENT A to use and share my health care and other personal information pertaining to my medical history, physical condition, and receipt of social services, and to communicate with each other in order to provide ECM services, OR
INITIAL HERE	**Decline to participate in ECM:** I understand that the ECM program permits community partners to communicate with each other to coordinate my care. I decline to participate in the ECM program. I can ask for participation in case management programs that I am eligible for.

Further, by initialing below, I specifically authorize release of the following information (this information will NOT be released unless you specifically authorize it)	
INITIAL HERE	Mental Health Information including: diagnosis, treatment plan, and provider name.
INITIAL HERE	HIV Test Results (Health & Safety Code § 120980 (g))

Substance Use Disorder Information

Substance use records are protected by federal confidentiality rules (42 CFR Part 2). The federal rules do not let any further disclosure of information that identifies a patient as having or having had a substance use disorder either by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. The federal rules restrict any use of the information to investigate or prosecute, with regard to acrime, any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

INITIAL HERE	Initial here to allow the entities in Attachment A to use and share ALL of your drug and alcohol information, including test results, treatment plans, programs attendance, communication with counselor and diagnosis.

Expiration and Revocation

Choose ONE of the following two options:

INITIAL HERE	**Standard expiration:** This authorization will expire exactly 5 years from today's date, OR
INITIAL HERE	**Early expiration:** This authorization will expire on:_____. This date may not be less than 6 months (to participate in the ECM program), nor more than 5 years from today's date.

This authorization may be withdrawn and revoked (taken back) at any time by calling PHC at (800) 863-4155 or by sending your signed request to: Partnership HealthPlan of California, Attn: Member Services 4665 Business Center Drrive, Fairfield, CA 94534. The revocation will take effect when PHC receives it, but does not affect information that has already been disclosed.

Signature of Member

I understand that:

- I may refuse to sign this authorization. My refusal could affect my ability to participate in theECM program. My refusal will not affect my ability to get treatment, services, or eligibility for benefits otherwise available to me.
- Some information shared under this Authorization may be re-shared with others under certainconditions and may no longer be protected by State and Federal confidentiality laws.
- 42 CFR part 2 does not allow re-disclosure of substance use records that are subject to that partwithout my authorization.
- I may inspect or get a copy of the health information that is being shared.
- I have a right to ask for a copy of this authorization and one will be sent to me.

Signature	Date
Printed Name	Relationship to Member

PHQ-9 Depression Screening & Blood Pressure Screening Template

Measurement Period: **January 1, 2023 - December 31, 2023**

Submission Frequency: **Quarterly** Submission Deadline: **2nd week of month following end of quarter**

Submission Method: **sFTP Folders** Submission Name Convention: **Facility Name_Dep-BP_Month-Year**

NOTE: *All columns for each entry must be completed. Incentive dollars will not be rewarded for incomplete entries.*

Provider Site Name (Physical Site)	Provider Number	Patient Name	CIN	DOB	PHQ-9 Depression Screening		Blood Pressing Screening	
					Screening Date	Score	Screening Date	Reading