



# Enhanced Care Management Quality Incentive Program

## Detailed Specifications 2025 Measurement Year

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## I. Partnership HealthPlan of California Program Contact Information

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Enhanced Care Management (ECM) Quality Improvement (QIP) team:

[ECMQIP@partnershiphp.org](mailto:ECMQIP@partnershiphp.org)

## II. Program Overview and Background

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Partnership HealthPlan of California's ECM QIP was launched based on the 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 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 2025 measurement year (January 1, 2025, through December 31, 2025) and divided into four quarterly measure periods. Specifications are subject to change based on DHCS' and Partnership's direction, and notification of changes will be made to all participating providers via the ECM QIP Team.

### Guiding Principles

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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.

### Participation Requirements

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All ECM contracted provider sites are automatically enrolled in the CalAIM Reporting Incentive Program and, therefore, are eligible to earn 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:

1. Provider is open for services to Partnership 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 DHCS or the federal government including the Centers for Medicare and Medicaid Services (CMS). If a provider appeals a sanction and prevails, Partnership will consider a request to change the provider status to good standing.
4. Provider is not pursuing any litigation or arbitration against Partnership.

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 Partnership on addressing community and member issues.
7. Provider is adhering to the terms of their contract (including following Partnership 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 Partnership.

In addition, Partnership has the sole authority to further determine if a provider is in good standing based on the criteria set forth above.

## **Payment Methodology**

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Participating ECM providers are evaluated based on the “Timely Reporting” 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 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.

### **Timely Reporting**

- Submissions are considered complete and will accrue 100% of incentive dollars if all three of the reporting requirements are submitted on or before their due date.
- Any submission(s) received up to one week or five business days past the due date will accrue at 50%.
- Any submission(s) not received within the five 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 January, a provider submits timely reports for 10 enrolled ECM members. A total of \$1,000 for the month of January will be placed in the incentive pool.

Incentive Pool Allotment: Providers may earn a percentage of the allotted incentive pool money by meeting one or more of the four other measures:

- Measure 1: up to 25% of total incentive pool
- Measure 2: up to 25% of total incentive pool
- Measure 3: up to 25% of total incentive pool
- Measure 4: up to 25% of total incentive pool

### Example:

- The provider has 10 patients and submits timely reports for three months in a quarter: 10 patients x \$100 (PMPM) x three months = \$3,000 placed in the incentive pool
- If the provider meets Measures 1, 2 and 3 with full credit, but did not meet Measure 4, the provider would earn 75% (25% for each of the measures met) x \$3,000 = \$2,250 incentive payment for the quarterly reporting period.

## Payment Data

Partnership 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. Partnership's EHS team (formerly titled 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: Partnership will allow retro TAR requests submitted up to one calendar month after the reporting month to be calculated in the denominator for incentive payments.

Partnership defines a retro TAR as a TAR submitted after the authorization start date that covers services already performed (i.e., a provider requests a TAR on January 15, 2025 for services starting December 25, 2024). To capture the most accurate member enrollment counts, not every retro TAR may fall under the grace period. Our EHS 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. Providers are encouraged to add enrolled members to the reporting files and submit TARs as soon as possible to meet 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 approximately 90 days after the close of each quarterly reporting period. Please refer to the payment schedule below.

Reporting Period	Payment Distribution
January - March 2025	June 2025
April - June 2025	September 2025
July - September 2025	December 2025
October - December 2025	March 2026

NOTE: Partnership HealthPlan of California reserves the right to adjust QIP payment timelines due to holidays and extensive validation processes. Any adjustment to payment timelines, including payment distribution, will be made via email from the ECM QIP team.



<p><b>PHQ-9 Depression Screening</b>  Document: <a href="#">PHQ-9 Depression Screening &amp; Blood Pressure Screening Template</a></p> <p>NOTE: Depression &amp; Blood Pressure screenings are submitted on <u>one</u> template.</p>	<p>Submit template <b>quarterly</b> via sFTP folder by 2nd Friday of the month following end of the quarterly reporting period:  Q1: 04/11/25, Q2: 07/11/25, Q3: 10/10/25, Q4: 01/09/26</p>
<p><b>Measure 3</b></p>	
<p><b>Blood Pressure Screening</b>  Document: <a href="#">PHQ-9 Depression Screening &amp; Blood Pressure Screening Template</a></p> <p>NOTE: Depression &amp; Blood Pressure screenings are submitted on <u>one</u> template.</p>	<p>Submit template <b>quarterly</b> via sFTP folder by 2nd Friday of the month following end of the quarterly reporting period:  Q1: 04/11/25, Q2: 07/11/25, Q3: 10/10/25, Q4: 01/09/25</p>
<p><b>Measure 4</b></p>	
<p><b>Timely review of emergency department (ED)/Admissions notifications in PointClickCare® (two-part measure)</b></p> <p><b>Part 1:</b> Set up the notification alerts function in PointClickCare®  <a href="#">PointClickCare Notifications Set-up &amp; Review Instructions</a></p> <hr/> <p><b>Part 2:</b> Review notifications in PointClickCare® within 72 hours of receiving notifications  <a href="#">PointClickCare Notifications Set-up &amp; Review Instructions</a></p>	<p><b>Part 1:</b>  Set up ED/Admissions notifications by end of quarterly reporting period  No reporting to Partnership required.</p> <hr/> <p><b>Part 2:</b>  Review ED/Admissions notifications within 72 hours of receiving notifications.  No reporting to Partnership required.</p>

\* Deadlines are subject to change based upon the necessary timeframes needed for file completion. Partnership will notify providers via email of any date changes. For questions regarding specific RTF, IOT and provider capacity survey due dates, please contact Partnership's EHS team at [ECM@partnership.org](mailto:ECM@partnership.org).

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## II. Gateway Measure: Timely Reporting

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### Description

The gateway measure determines the number of dollars available for the program's four reporting measures. Reports for Return Transmission File (RTF), Initial Outreach Tracker File (IOT), and Provider Capacity Survey are required to be submitted monthly in order to participate in the other measures of the program.

### Measurement Period

January 1, 2025 – December 31, 2025

Quarterly reporting period: Q1 (Jan-Mar), Q2 (Apr-Jun), Q3 (Jul-Sep), Q4 (Oct-Dec)

### Thresholds

Timely Reporting Requirements	Earned Incentive Pool
All three required reports submitted on or before due date	100% incentive dollars placed in incentive pool (\$100 PMPM)
All three required reports submitted up to one week or five business days past due date	50% incentive dollars placed in incentive pool (\$50 PMPM)
Any submission(s) not submitted within the five business days	No incentive dollars placed in incentive pool

### Reporting Requirements

Measures and Documents	Deadline and Reporting Requirements
<b>Gateway Measure: Timely Reporting</b>	
<b>ECM Provider Return Transmission File (RTF)</b> Document: <a href="#">Provider Return Transmission File (RTF)</a>	Submit <b>monthly</b> to EHS team via sFTP folder. (Refer to due date schedule from EHS team)
<b>ECM Provider Initial Outreach Tracker File (IOT)</b> Document: <a href="#">Provider Initial Outreach Tracker File (IOT)</a>	Submit <b>monthly</b> to EHS team via sFTP folder. (Refer to due date schedule from EHS team)
<b>Provider Capacity Survey</b> Survey document provided by EHS team	Submit <b>monthly</b> to EHS team via MS Docs. (Refer to due date schedule from EHS team)

\* Deadlines are subject to change based upon necessary timeframes needed for file completion. Partnership will notify providers via email of any date changes. For questions regarding specific RTF, IOT and provider capacity survey due dates, please contact Partnership's EHS team at [ECM@partnershiphp.org](mailto:ECM@partnershiphp.org).

## V. Reporting Measures

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### Measure 1. Care Plan and Release of Information Form Upload to PointClickCare

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#### Description

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As a requirement of the contract, for all ECM enrolled members, providers are required 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**.

Partnership and DHCS ROI forms contain a five-year expiration. Unless indicated by the member to end the ROI earlier, the ROI form only needs to be uploaded into PointClickCare® when the member is enrolled (first TAR request date). Providers may use their own ECM-specific ROI form; however, the 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

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January 1, 2025 – December 31, 2025

Quarterly reporting period: Q1 (Jan-Mar), Q2 (Apr-Jun), Q3 (Jul-Sep), Q4 (Oct-Dec)

#### Thresholds

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Eligible Incentive: 25% of total incentive pool

- PASS (Full credit):  $\geq 70\%$  of Care Plans and ROI forms uploaded into PointClickCare®
- PASS (Partial credit): 60 - 69% of Care Plans and ROI forms uploaded into PointClickCare®

NOTE: The threshold for this measure was lowered at the end of 2024 to account for the use of sample size auditing methodology. The overarching goal for all enrolled ECM members to have a care plan and ROI uploaded within 60 days of TAR request date, and retrievable in PointClickCare®, remains the same. Any appeals will only be applied to the accuracy of reviewing the sampled enrolled members in PCC, not based on comparison to the rate obtained by other methods.

#### Denominator

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ECM members enrolled in one or more of the ECM populations of focus

#### Numerator

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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

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None

## Reporting Requirements

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No reporting to Partnership is required. Providers must upload care plans and ROI forms into PointClickCare® within 60 days of the TAR request date and TAR renewal request date. Partnership will audit a sample size of members in PointClickCare® for evidence of care plans and ROI forms uploaded into PointClickCare® within the required deadline.

## Measure 2. PHQ-9 Depression Screening

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### Description

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Depression screening using the Patient Health Questionnaire-9 (PHQ-9) must 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 results must be documented in the case management record for potential audit.

Depression screening must be completed annually (every 12 months) at a minimum. For this measure, depression screening scores from previous quarters can be used if score was captured within 12 months of the last screening **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) tool to complete a screening; however, if the PHQ-2 score is 3 or higher, providers must complete the screening using the PHQ-9.

NOTE: Screening dates after the end of the quarterly reporting period will not receive credit.

### Other Depression Screening Tool Options

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The following three depression screening tool options are also approved for screening members:

#### Members with intellectual and/or development disabilities:

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

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

#### Youth members - 11-17 years:

The **Severity Measure for Depression - Child Age 11–17 (adapted from PHQ-9 modified for Adolescents) [PHQ-A]** assesses the severity of depressive disorders and episodes (or clinically significant symptoms of depressive disorders and episodes) in children ages 11–17. The tool is completed by the child prior to a visit with the clinician.

If you encounter challenges with screening a member for depression which does not fall into the above categories, please contact the ECM QIP Team.

### Measurement Period

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January 1, 2025 – December 31, 2025

Quarterly reporting period: Q1 (Jan-Mar), Q2 (Apr-Jun), Q3 (Jul-Sep), Q4 (Oct-Dec)

## Thresholds

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Eligible Incentive: 25% of total incentive pool

- Full credit:  $\geq 90\%$  of submitted and approved depression screenings
- Partial credit: 80 - 89% of submitted and approved depression screenings

## Denominator

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ECM members, 12 years of age or older, enrolled in one or more of the ECM populations of focus

## Numerator

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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

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Members 11 years of age and younger

## Reporting Requirements

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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 PHQ-9 depression screening date and score. **The template must be submitted quarterly through the sFTP folder by the second Friday of the month following the end of the quarterly reporting period.**

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

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### Description

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Blood pressure screening must be completed for all ECM enrolled members, 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 a Partnership HealthPlan of California approved home blood pressure kit. Blood pressure screening results must be documented in the case management record for potential audit.

In general, blood pressure screening should be completed annually (every 12 months) at a minimum. For this measure, blood pressure screening results from previous months can be used if captured within 12 months of the last screening **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 SBP  $\geq$  (equal to or greater than) 140 or DBP  $\geq$  (equal to or greater than) 90, providers must complete the screening every quarter until the result is normal.

NOTE: Screening dates after the end of the quarterly reporting period will not receive credit.

### Measurement Period

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January 1, 2025 – December 31, 2025

Quarterly reporting period: Q1 (Jan-Mar), Q2 (Apr-Jun), Q3 (Jul-Sep), Q4 (Oct-Dec)

### Thresholds

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Eligible Incentive: 25% of total incentive pool

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

### Denominator

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ECM members, 18 years of age and older, enrolled in one or more of the ECM populations of focus

### Numerator

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

### Exclusions

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Members 17 years of age and younger

### Reporting Requirements

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ECM providers must complete ALL columns of the PHQ-9 Depression Screening and 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 quarterly through the sFTP folder by the second Friday of the month following the end of the quarterly reporting period.**

## Measure 4. Timely Review of ED/Admissions Notifications

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### Description

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This two-part measure focuses on providers reviewing notifications received when members visit the emergency department (ED) or are admitted to the hospital. Providers are required to set up the notification alerts function in PointClickCare® for ED/Admissions cohorts (Part 1) and review these notifications within 72 hours of receiving notification alerts in PointClickCare® (Part 2).

NOTE: Parts 1 and 2 must be completed in separate quarterly reporting periods. New ECM providers are required to complete Part 1 of this measure during their first quarter participating in the program.

### Measurement Period

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January 1, 2025 – December 31, 2025

Quarterly reporting period: Q1 (Jan-Mar), Q2 (Apr-Jun), Q3 (Jul-Sep), Q4 (Oct-Dec)

### Part 1: Notifications Set-up in PointClickCare®

As a prerequisite for participation in Part 2, providers are required to set up the Notification Alerts function in PointClickCare®. Providers must contact PointClickCare® for assistance. Please review [PointClickCare Notifications Set-Up and Notifications Review Instructions](#) on Partnership's [ECM QIP webpage](#).

### Incentive

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Eligible Incentive: 25% of total incentive pool. No partial credit.

### Reporting Guidelines

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No reporting is required by providers. Partnership will verify with PointClickCare® that Notification Alert functions and correct cohorts are set up properly.

### Part 2: Timely Review of ED/Admissions Notifications in PointClickCare®

Providers are required to review notifications received in PointClickCare® within 72 hours of receiving notification alerts.

NOTE: 72 hours includes all national holidays. The thresholds for this measure have been lowered to account for the 3- or 4-day weekends which occur about 11 times per year.

### Thresholds

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Eligible Incentive: 25% of total incentive pool

- PASS (Full credit):  $\geq 70\%$  of reviewed notifications
- PASS (Partial credit): 60% - 69% of reviewed notifications

NOTE: Providers with a denominator of five or less members with an emergency department visit/admission in a quarter will receive credit for having the alerts set up in their system (i.e. the first quarter measure).

## Exclusions

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No exclusions

## Reporting Guidelines

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No reporting to Partnership is required. Partnership will obtain performance results from PointClickCare®.

