*We heal and inspire the human spirit.*

**To:** Medi-Cal PCPs

**From:** IEHP – Practice Transformation

**Date:** September 26, 2023

**Subject: Equity and Practice Transformation (EPT) Program FAQs & Links to Information**

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Thank you for attending our **Equity and Practice Transformation (EPT) Provider Directed Payment Program** meeting. Below is the information we promised to share and on the next page are **EPT FAQs**.

If you were not able to attend, but are interested in learning more about this program, please review the following links:

- **DHCS EPT Payments Program**: Equity and Practice Transformation (EPT) Payments Program (ca.gov) or DHCS.ca.gov and search "EPT"

- **PhmCAT**: https://phminitiative.com/phmcat/

  - Population Health Management Capabilities Assessment Tool (PhmCAT) is a multi-domain assessment that is used to understand current population health management capabilities of primary care practices or community health centers. This self-administered tool can help organizations identify strengths and opportunities for improving population health management. It can also be used to assess changes over time if administered at multiple time points.

- **EPT Provider Application**: DHCS EPT Provider Directed Payment Program Application (Page 1 of 11) (office.com)

- **IEHP Provider EPT Webinar Recording**: https://vimeo.com/866826238?share=copy

If you're receiving this via blast fax, and wish to receive a copy of the Power Point and other notices via email, please send your request to providercommunication@iehp.org

If you have further questions, please reach us at EPTProgram@iehp.org

As a reminder, all communications sent by IEHP can also be found at: www.iehp.org > For Providers > Plan Updates > Correspondence

9/26/2023
Version 1.0

**IEHP Equity Practice Transformation FAQs**

1. Are practices required to participate in all three "required categories" or are they able to select one?

   **Answer: All three.**

2. Under the three required categories, are practices required to commit to or attest to completing all 13 activities? Or are they able to select a few activities in each category?

   **Answer: Practices must attest or commit to all activities in the three required categories.**

   **If a practice has already addressed an activity but wants to do further work on that activity (e.g the practice's EHR was recently upgraded but now the practice is migrating to another EHR), the practices can commit to that activity.**

3. For the Patient Centered, Population Based Care category, practices must commit to all activities. Does this mean practices cannot attest to having completed some of the activities in this category?

   **Answer: Correct, there is no option to attest to completed activities in the Patient Centered, Population Based Care category. All practices must commit to all activities in this category.**

4. Once providers submit EPT applications through the DHCS Web portal, when and how will Managed Care Plans (MCPs), like IEHP, be notified and receive the applications?

   **Answer: After the application portal closes on October 23, DHCS will send applications to the MCP indicated by the practice on October 24 and October 25.**

5. Are practices able to apply per office location, given that the demographic of members at each location may fall into different populations of focus?
   Or are practices only able to submit one application for all locations? If practices are only allowed one application, can the practice specify that the funding would be used for some locations and not others?

   **Answer: Each single legal entity may only submit a single application.**
   **A single legal entity can choose a subset of specific locations (if they have multiple locations) to participate. In that case, the assigned count of Medi-Cal patients (for the total max payment) should be based on the lives attributable only to the participating locations.**
   **See the bottom of page 10 of the Guidelines for more information, specifically the statement "*Larger practices may apply for a limited number of locations within the larger organization (e.g. two physical sites across all physical sites); only the locations specified in the EPT application would be committing to the expectations of the Provider Directed Payment Program*".**

6. For Patient-Centered Population-Based care - for Children and Youth - what ages are included?

   **Answer: IEHP is pending a response from DHCS. We will advise when response is provided.**

7. Is there a minimum number of Activities that need to be selected?

   **Answer: Yes. All thirteen (13) activities under the three required categories (Empanelment and Access, Technology and Data, Patient-Centered Population Based Care) need to be either committed or attested to.**
   **Additionally, all seven (7) activities under the category "Patient-Centered, Population-Based Care" are required. Groups cannot attest to these activities for past actions.**
   **For the remaining one (1) activity under the category "Empanelment and Access", and five (5) activities under "Technology and Data", those activities must either be committed to, or attested to have already been completed.**

8. If practices have fewer than 500 Medi-Cal and D-SNP patients but are steadily growing, should the practice apply or does the practice need to wait until the practice has the minimum panel criteria of 1000 assigned Medi-Cal and D-SNP patients?

   **Answer: Total Medi-Cal & D-SNP assigned lives are determined at time of application. Prospective lives that may be assigned in the future are not included. Organizations must serve at least 1,000 assigned Medi-Cal Members (or 500 Medi-Cal patients for rural providers) at the time of application.**

9. How does a group apply for the Initial Planning Incentive Payments?

   **Answer: Providers are not eligible to apply for the Initial Planning Incentive Payments Program. This program is for MCPs only. MCPs will identify and work with small- to medium-sized independent practices using a standardized assessment tool (phmCAT) to provide support as the practices develop EPT Provider Directed Payment Program plans and applications.**

10. The EPT program appears to be geared towards support of primary care practices, but can our local medical societies seek to partner on an application?

    **Answer: Medical Societies do not meet the minimum practice eligibility criteria to participate directly in the EPT Directed Payment program, as the program is only available to primary care practices that receive patient assignment from a contracted Medi-Cal Managed Care Plan.**
    **However, MCPs may seek assistance from medical societies to identify and work with small- to medium-sized independent practiced using a standardized assessment tool (phmCAT) to support practices as they develop EPT Provider Directed Payment Program plans and applications.**

11. Can any size practice apply for the EPT Provider Directed Payment Program?

    **Answer: In terms of number of providers at a practice, there is no limits based on the number of practitioners. Only the number of assigned Medi-Cal patients through a practice limit the application to the program. See question 8 above.**

12. The payment program application link on the DCHS website requires a password. Does this seem right?

**Answer: There is no longer a username and password required to access the Provider Directed Payment Program Application Instructions on the DHCS EPT website.**

13. Will you be sending the links to the Application guideline?

    **Answer: Yes.**

14. If a provider is involved in other programs such as Enhanced Care Management (ECM) and are already participating in the activities included in the EPT program, can these activities be attested to?

    **Answer: Yes, if the activities do not fit under the "Patient Centered, Population-Based Care" category. Activities in these categories must be completed as part of the program. However, a new activity added to existing ECM service activities would meet this requirement.**

15. What about the initial planning incentive payment to help get ready? Considering there is less than a month left for practices to submit their EPT application, practices will need support for the required additional time, effort, and staffing.

    **Answer: IEHP is working to contract with additional local resources to assist practices with their phmCAT and application upon request. In the meantime, IEHP is available to assist with questions at** EPTProgram@iehp.org.

# Equity & Practice Transformation (EPT) Provider Directed Payment Program

September 20, 2023

# Agenda

1. IEHP Introductions
2. EPT Provider Directed Payment Program Presentation Review
3. Application Instructions
4. Q&A

# IEHP EPT CORE TEAM

Dr Takashi Wada
Chief Medical Officer

Esther Iverson
Director, Provider Communications

Genia Fick
Vice President, Quality

Lorena Chandler
Vice President, Health Equity

Matthew Wray
Director, Health Services
Special Initiatives

Nishtha Patel
Special Programs
Manager

# Overview of EPT Payments Program

» **Funding**: One-time $700M initiative

» **Goal** is to improve primary care for Medi-Cal recipients:

- Advance equity
- Reduce COVID-19-driven care disparities
- Invest in up-stream care models/partnerships to address health/wellness
- Fund practice transformation aligned with value-based payment models

Norris, Jeff@DHCS

# Program Aligned with Key Priorities

- DHCS Comprehensive Quality Strategy
- Health Equity Roadmap
- 50 X 2025: Bold Goals

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# EPT Payments Program

| Program Component | Intended Practices | Application | Purpose/Deliverable |
|---|---|---|---|
| **Initial Planning Incentive Payments**<br>$25M first year of program<br>Managed Care Plan (MCP) incentive program | **Small/medium-sized independent practices (1-50 providers)** that might not otherwise be able to participate in Provider Directed Payment Program; **MCPs choose practices** | Practices **work with contracted MCPs**<br>(no formal application to DHCS) | **Practices complete practice assessment tool** phmCAT as PDF and get practice transformation support from MCPs/contractors<br>Goal is to **increase # of practices that apply for Provider Directed Payment Program** |
| **Provider Directed Payment Program**<br>$650M ($200M for preparing practices for value-based payment) over multiple years<br>Directed payment program | **Primary care of any size or setting:** primary care Pediatrics, Family Medicine or Internal Medicine; primary care OB/GYN; and/or behavioral health providers providing integrated behavioral health services in a primary care setting | **Formal web-based application** | **First cohort January 2024**<br>Payments for **delivery system transformation activities** |
| **Statewide Learning Collaborative**<br>$25M for program duration<br>Structure still being determined | **All practices in Provider Directed Payment Program** | None | Provide **support to practices with practice transformation**; will be largely modeled on PHMI materials |

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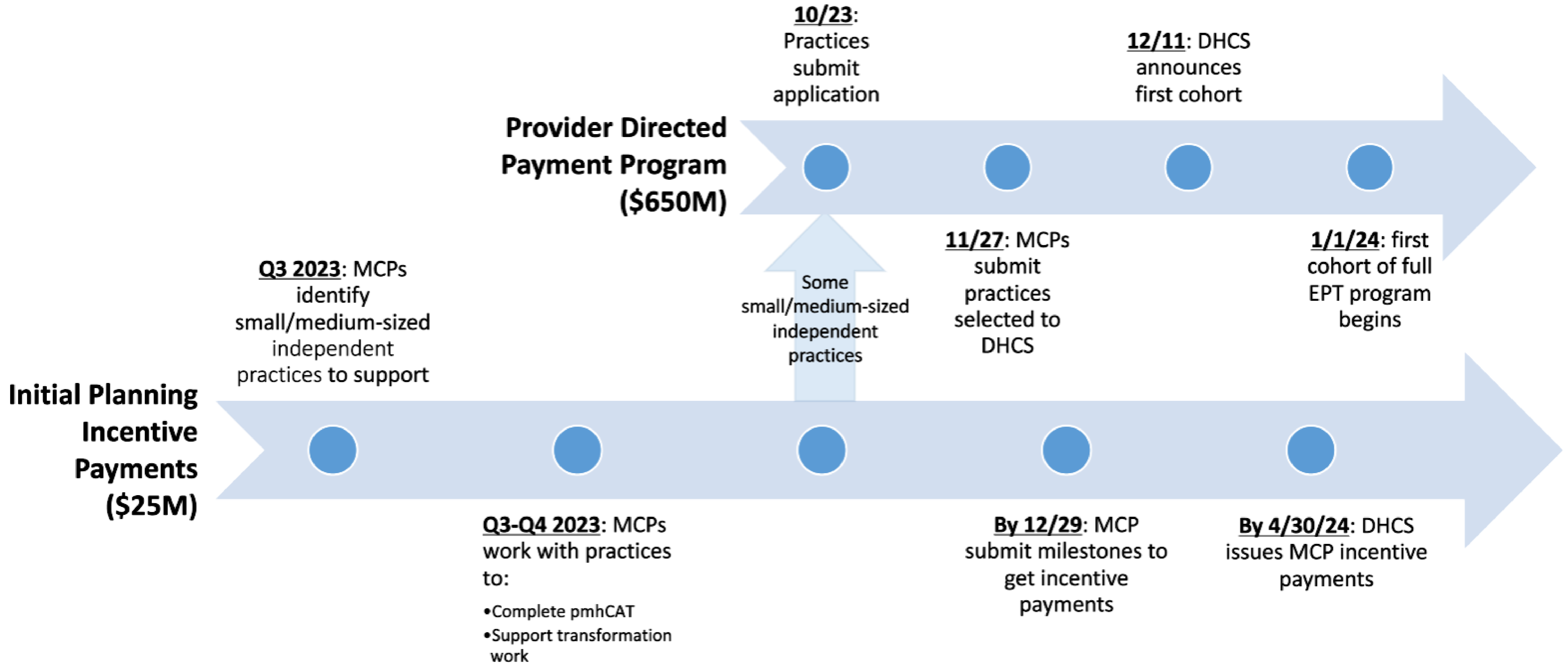
# What is a "directed payment program"?

- **CMS approved payment methodology** under CFR 42 438.6
  - Requires specific reimbursement to providers in Medicaid managed care
  - CMS must approve each program through a "preprint"
- **The Provider Directed Payment Program is a directed payment program;** practices **can only get payment for completed activities/measures during program** rather than anything done in the past

# Timelines

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# Provider Directed Payment Program

$650 million

DHCS

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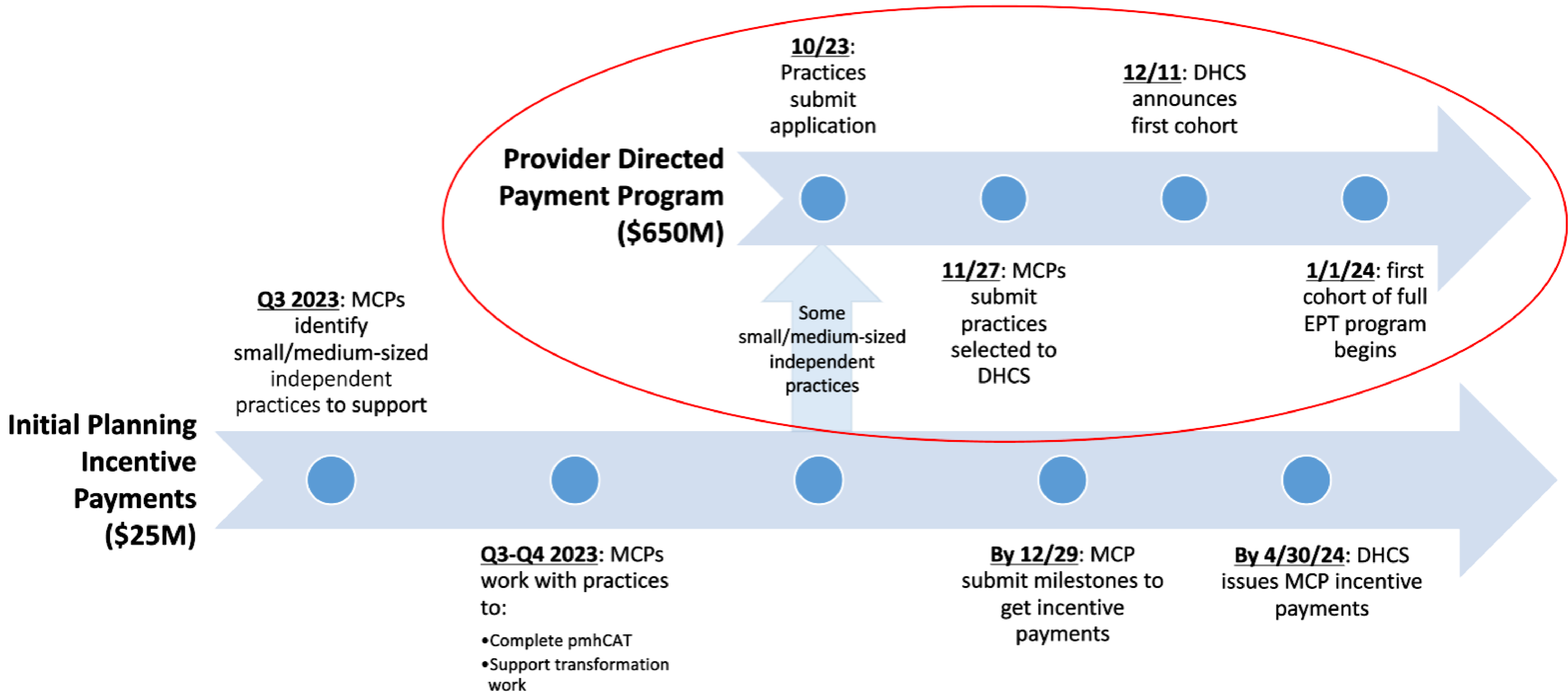
# Timelines

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# Categories of Activities

## (which align with pmhCAT and Implementational Model)

### Required Categories

- Empanelment & Access
- Technology & Data
- Patient-Centered, Population-Based Care (focused on specific patient population)

### Other Categories (Optional)

- Evidenced-Based Models of Care
- Value-Based Care & Alternative Payment Methodologies
- Leadership & Culture
- Behavioral Health
- Social Health

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# Application Guidance/Structure

- Applicants may **apply for payments in multiple categories and activities**
- **Categories and activities will not always be mutually exclusive**; e.g. a single project might include multiple categories and activities
- **"Example Steps" (see Guidelines document to posted to EPT website) are included as examples** of what practices might engage in during program; final milestones (akin to deliverables) will be released in Q4 2023
- **pmhCAT completion is recommended (not required)** prior to completing an application (as it will guide practices on what activities to apply for); pmhCAT will be required for those accepted into program

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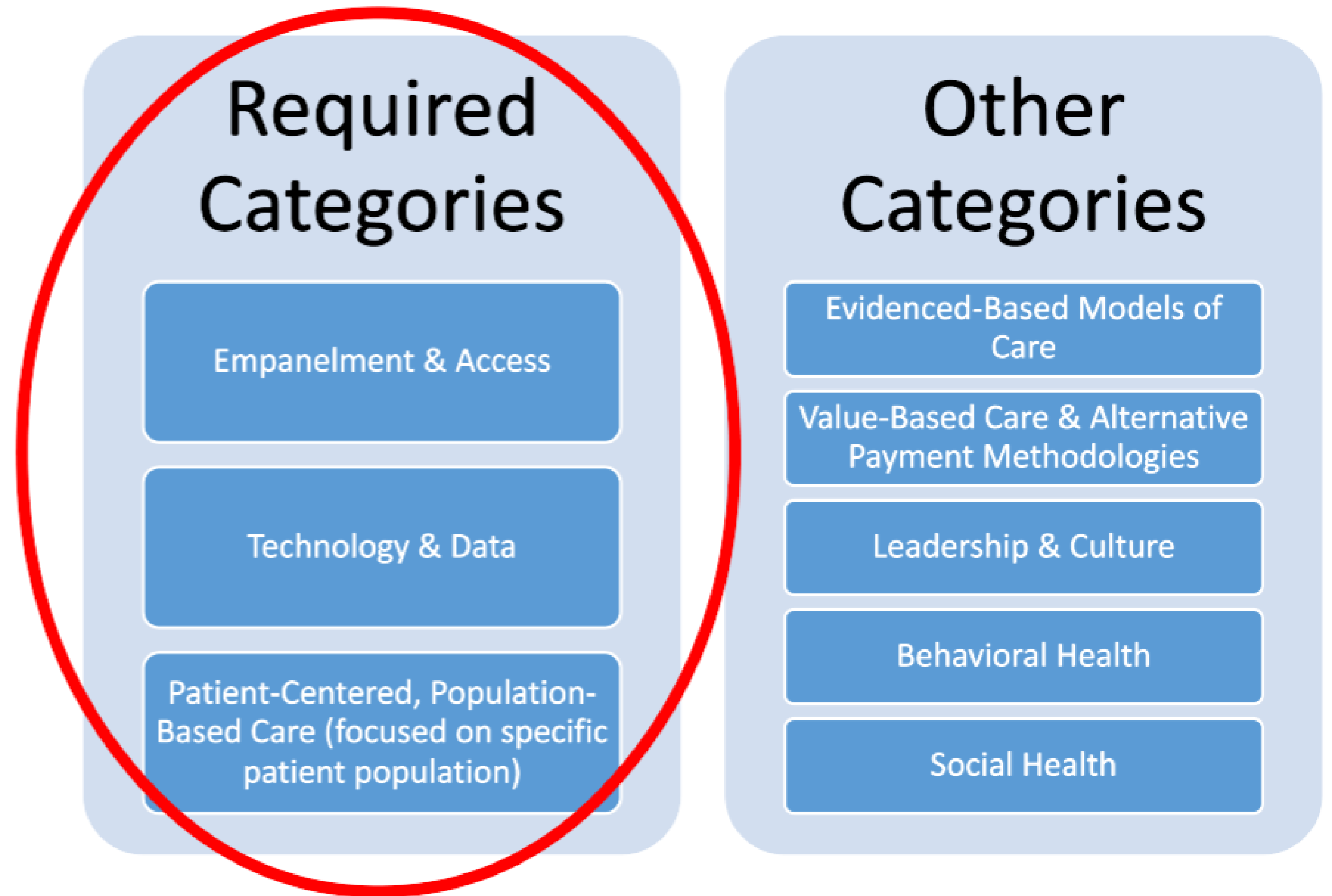
# Required Categories & Activities

- **All activities in these categories are <u>required</u>**
- For "Empanelment & Access" and "Technology & Data", practices must either:
  - Apply for the uncompleted activities in these categories, OR
  - Attest that they have addressed the activities (though if a practice wants to for further work in this area, they can still apply for an already addressed activity)
- For "Patient-Centered, Population-Based Care", practices must commit to all activities

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# Maximum Payment Based on Assigned Medi-Cal Lives (at time of application)

| Medi-Cal & D-SNP Assigned Lives Range (at time of application) | Maximum Payment (over all categories) |
|---|---|
| 500-1,000 | $375,000 |
| 1,001-2,000 | $600,000 |
| 2,001-5,000 | $1,000,000 |
| 5,001-10,000 | $1,500,000 |
| 10,001-20,000 | $2,250,000 |
| 20,001-40,000 | $3,750,000 |
| 40,001-60,000 | $5,000,000 |
| 60,001-80,000 | $7,000,000 |
| 80,001-100,000 | $9,000,000 |
| 100,001+ | $10,000,000 |

Funding subject to CMS approval

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# Funding Distribution

- **Funding is proportionally divided** among activities
- For example, if a practice commits to **10 activities**, the funding will be allocated as **1/10 of the total for each activity** (which will be further divided into funding for milestones)
- Maximum **payments may be reduced by DHCS based on the number of activities selected**

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# PPS-Reimbursed Clinics

- Payments in the Provider Directed Payment Program are **not subject to annual Medi-Cal reconciliation**
- MCPs **must**, and practices are **urged to**, **keep track of payments for audit purposes** (e.g. in general ledger)

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# Overview of Practice Requirements

| | Required | Optional |
|---|---|---|
| Primary Care Practice (including integrated behavioral health), regardless of size | X | |
| Funding Limit Based on Medi-Cal Assigned Lives | X | |
| Web-based Application by 10/23/23 | X | |
| Prospectively commit to specific activities, starting 1/1/24 | X | |
| Participate in Statewide Learning Collaborative (held at least monthly) | X | |
| Apply for all "required category" activities or attest to prior achievement | X | |
| Choose focus population (and sub-population) | X | |
| Complete pmhCAT | Will be required in 2024 for practices accepted, including meeting to review results | Recommended before completing application |
| Applying for funding in areas beyond "required" categories | | X |

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# Required Categories & Activities

## Required Categories

- Empanelment & Access
- Technology & Data
- Patient-Centered, Population-Based Care (focused on specific patient population)

## Other Categories

- Evidenced-Based Models of Care
- Value-Based Care & Alternative Payment Methodologies
- Leadership & Culture
- Behavioral Health
- Social Health



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# Empanelment & Access: Activity

Empanelment & Access

**GOAL:** Identify a staff member who serves as panel manager, conduct initial patient assignment and supply/demand balancing, and implement ongoing management (panel monitoring, access metrics like third-next available appointments, empanelment, reports and panel adjustments

Example steps listed in program guidelines

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# Technology & Data: Activities

**Population Health and Quality Improvement Governance**

**GOAL:** develop and implement a formal structure for population health and quality improvement, including regular meetings of key practice stakeholders whom review data and develop/implement strategies to improve population health and quality

**Dashboards and Business Intelligence**

**GOAL:** determine the practice's key performance indicators (KPIs, inclusive of HEDIS metrics), collect ongoing data to evaluate KPIs, and present and disseminate KPI reports to stakeholders using business analytics tools (e.g. Excel, Power BI, Tableau, Arcadia, or another similar tool)

Example steps listed in program guidelines

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# Technology & Data: Activities

**Data and Quality Reporting Gaps**

**GOAL:** determine, create, and implement a formal strategy to address gaps in data that includes a data validation process that identifies gaps and solutions for improving data quality, such as reconciliation with MCPs; data can refer to quality, operational, billing, population health, or other data

**New/Upgraded Electronic Health Record (EHR) and/or Population Health Management Tool**

**GOAL:** ensure the practice has the EHR and/or population health management tools need to maximize clinical, operational, financial, and population health needs. This activity is considered already met if the practice already has the tools they deem necessary

Example steps listed in program guidelines

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# Technology & Data: Activities

**Data Exchange**

**GOAL:** establish, maintain, and use bilateral data feeds with a Data Exchange Framework (DxF) Qualifying Health Information Organization, as defined by the current DxF framework and to be further defined in future DxF policies

Example steps listed in program guidelines

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# Patient-Centered, Population-Based Care Activities: Focus Population

- For this category, applicants **must choose primary focus population to work with and a further subpopulation**
- **Activities within this category remain the same** regardless of population
- **Focus populations** to choose from are below (all populations are part of larger strategic DHCS efforts):
  - Birthing populations (pregnancy and up to 12 months postpartum)
  - Children and youth
  - Adults with preventive care needs
  - Adults with chronic conditions
  - People living with behavioral health conditions

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# Patient-Centered, Population-Based Care Activities: Sub-Population

- Practices **must also choose a further subpopulation (subgroup of larger focus population)**
  - Will be a focus of further health equity work 2-3 years into EPT program
  - Efforts will focus on **tailoring the care team model to better meet the needs of the subpopulation and reduce health disparities**
- **Subpopulation options limited to**:
  - Transitioning from incarceration
  - People experiencing homelessness
  - Adults at risk of needing or receiving long-term care placement services
  - Individuals with behavioral health conditions (including substance use disorders)
  - Populations experiencing disparities because of race/ethnicity
  - Foster youth
  - LGBTQ+

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# Patient-Centered, Population-Based Care: Activities

## Care Team Design and Staffing

**GOAL:** Define and implement a care team that addresses population health management functions (e.g., gaps in care closure, care coordination) and team-based care for the population of focus

## Stratification to Identify Disparities

**GOAL**: Use data to stratify services and/or outcomes measures by a socioeconomic variable that can identify health disparities (e.g. race/ethnicity, sexual orientation/gender identity, etc.), and implement a strategy to decreases any disparities identified

Example steps listed in program guidelines

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# Patient-Centered, Population-Based Care: Activities

| | |
|---|---|
| Clinical Guidelines | **GOAL:** choose and implement evidence-based clinical guidelines |
| Implement condition-specific registries | **GOAL:** create, implement, and use condition-specific registries |

Example steps listed in program guidelines

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# Patient-Centered, Population-Based Care: Activities

| | |
|---|---|
| Proactive Patient Outreach and Engagement | **GOAL:** create and implement a formal strategy to better engage and outreach to patients, including patients assigned by not seen |
| Pre-visit Planning and Care Gap Reduction | **GOAL:** create and implement a formal process for pre-visit planning (that at minimum addresses gaps in care) |

Example steps listed in program guidelines

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# Patient-Centered, Population-Based Care: Activities

Care Coordination

**GOAL:** create and implement a formal strategy to address care coordination needs for patients with more complex health and social needs

Example steps listed in program guidelines

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# Other Categories (Optional)

## Required Categories

- Empanelment & Access
- Technology & Data
- Patient-Centered, Population-Based Care (focused on specific patient population)

## Other Categories

- Evidenced-Based Models of Care
- Value-Based Care & Alternative Payment Methodologies
- Leadership & Culture
- Behavioral Health
- Social Health



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# Evidenced-Based Models of Care

New/Expanded Care Delivery Model

**GOAL:** Choose and implement an evidenced-based model of care for focus population (e.g. Dyadic Care, Centering pregnancy, group visits for conditions like diabetes, Project Dulce, Collaborative Care Model for behavioral health, Medication Assisted Treatment, etc.)

Example steps listed in program guidelines

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# Value-Based Care & Alternative Payment Methodologies: Activities

## FQHC APM

**GOAL:** for FQHCs only, complete readiness activities for the APM, apply for the FQHC APM, prepare for APM implementation, and implement the APM (FQHCs who have applied for and been accepted CAN still choose this activity)

## Value-Based Payment

**GOAL:** complete readiness activities and then begin a value-based contract with at least one Medi-Cal MCP (consistent with HCP-LAN category 3 or 4)

Example steps listed in program guidelines

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# Leadership & Culture: Activities

**DEI Strategy**

**GOAL:** create and implement an organizational-wide strategy to work on diversity, equity, and inclusion (DEI)

**Strategic Planning**

**GOAL:** create and implement a formal process to address the practice's strategic planning (which must, at minimum, address DEI and patient and community partnership/engagement, patient access, quality metrics, health equity, workforce satisfaction and retention, and value-based care)

Example steps listed in program guidelines

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# Leadership & Culture: Activities

Patient and Community Partnership/ Engagement

**GOAL:** choose and implement a strategy to ensure patient and community input on practice governance and decision making (e.g., a patient advisory committee, seeking to increase patient representation on the organization's board, etc.)

Example steps listed in program guidelines

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# Behavioral Health: Activities

**Integrating Behavioral Health in Primary Care**

**GOAL**: Integrate behavioral health into primary care practice to provide more comprehensive care for patients.

Example steps listed in program guidelines

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# Social Health: Activities

Social Needs/Risk Screening and Intervention

**GOAL:** create and implement a formal process for screening for and intervening on patients' social needs/risks

Example steps listed in program guidelines

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# APPLICATION

INSTRUCTIONS AND DUE DATES

# Application

- The application and application instructions are available on DHCS website.
- Practices are encouraged to review application instructions prior to starting application- the application will need to be completed in one session
- Practices must complete a PhmCAT assessment at https://phminitiative.com/resources/

**Applications are due October 23, 2023**

# Resources

- Application instructions: https://www.dhcs.ca.gov/qphm/Documents/EPT-Provider-Directed-Payment-Program-Application-Instructions.pdf
- FAQs: https://www.dhcs.ca.gov/qphm/Documents/Equity-and-Practice-Tranformation-Frequently-Asked-Questions.pdf
- phmCAT tool: https://phminitiative.com/
- DHCS EPT Website: https://www.dhcs.ca.gov/qphm/pages/eptprogram.aspx

# QUESTIONS?

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