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

Public Webinar, 8/30/2023

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Objectives

- Describe the overall EPT Payments Program structure, timelines, and goals
- Provide details on the Provider Directed Payment Program application process and roles/responsibilities
- List next steps for applicants and stakeholders

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

Program Aligned with Key Priorities

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

EPT Payments Program

Program Component	Intended Practices	Application	Purpose/Deliverable
Initial Planning Incentive Payments $25M first year of program 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** (no formal application to DHCS)	**Practices complete practice assessment tool phmCAT as PDF** and get practice transformation support from MCPs/contractors Goal is to **increase # of practices that apply for Provider Directed Payment Program**
Provider Directed Payment Program $650M ($200M for preparing practices for value-based payment) over multiple years 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** Payments for **delivery system transformation activities**

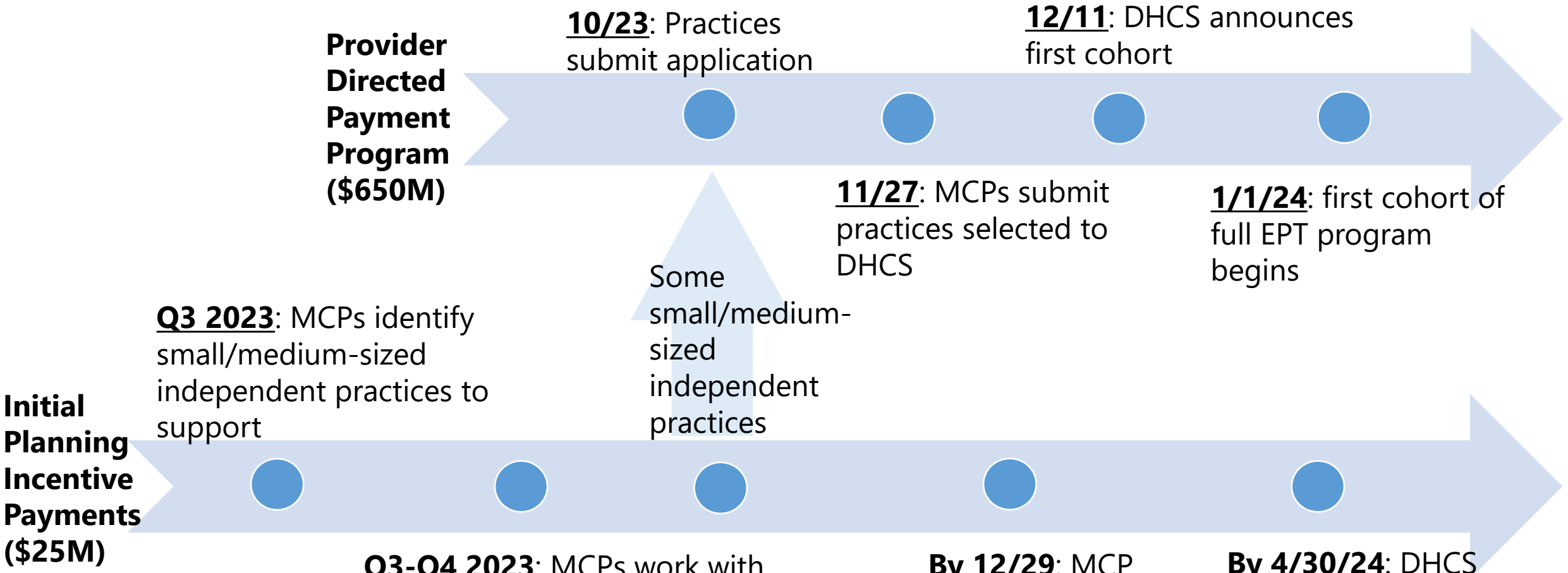
EPT Payments Program

Program Component	Intended Practices	Application	Purpose/Deliverable
Statewide Learning Collaborative $25M for program duration 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

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


Provider Directed Payment Program ($650M)
10/23: Practices submit application
11/27: MCPs submit practices selected to DHCS
12/11: DHCS announces first cohort
1/1/24: first cohort of full EPT program begins
Initial Planning Incentive Payments ($25M)
Q3 2023: MCPs identify small/medium-sized independent practices to support
Some small/medium-sized independent practices
Q3-Q4 2023: MCPs work with practices to:
• Complete pmhCAT
• Support transformation work
By 12/29: MCP submit milestones to get incentive payments
By 4/30/24: DHCS issues MCP incentive payments

Initial Planning Incentive Payment Updates

Previously launched in July 2023

$25 million

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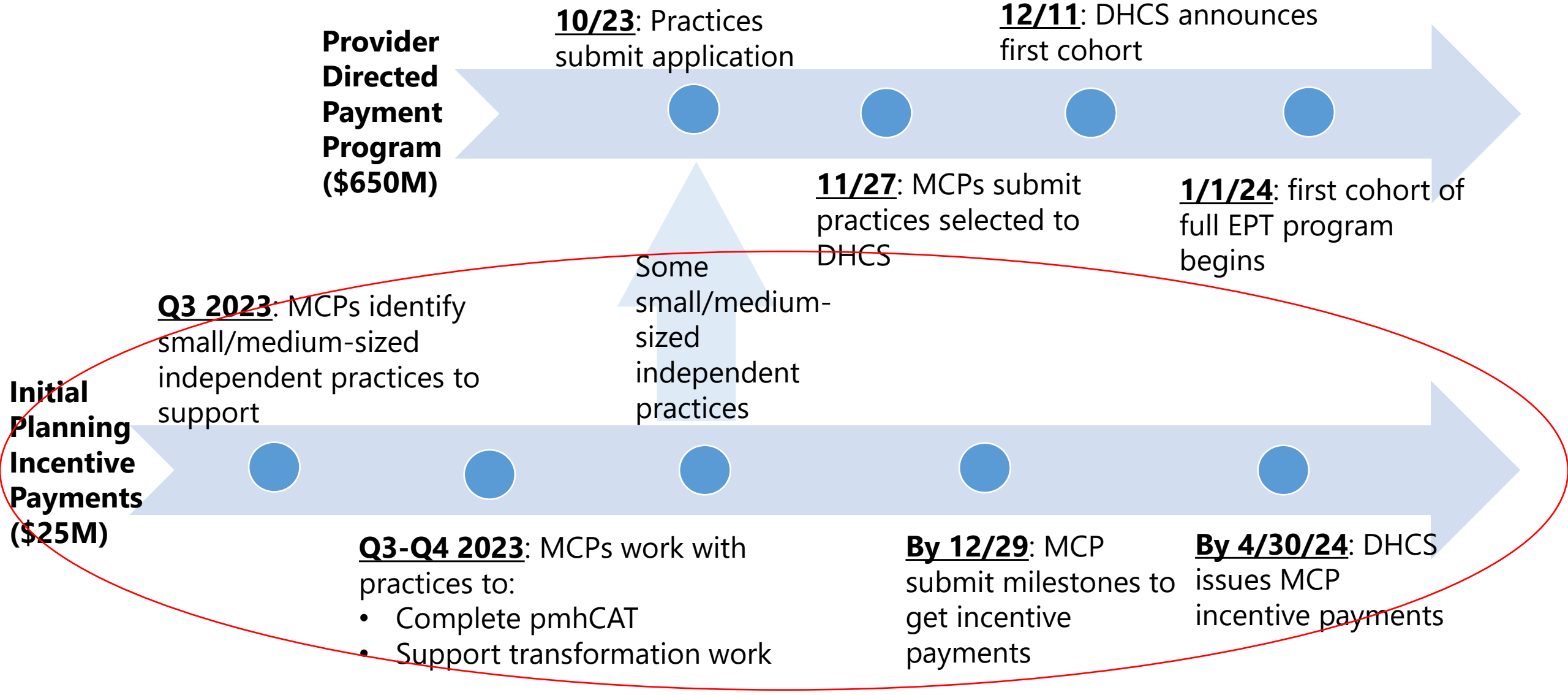
Timelines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Provider Directed Payment Program

$650 million

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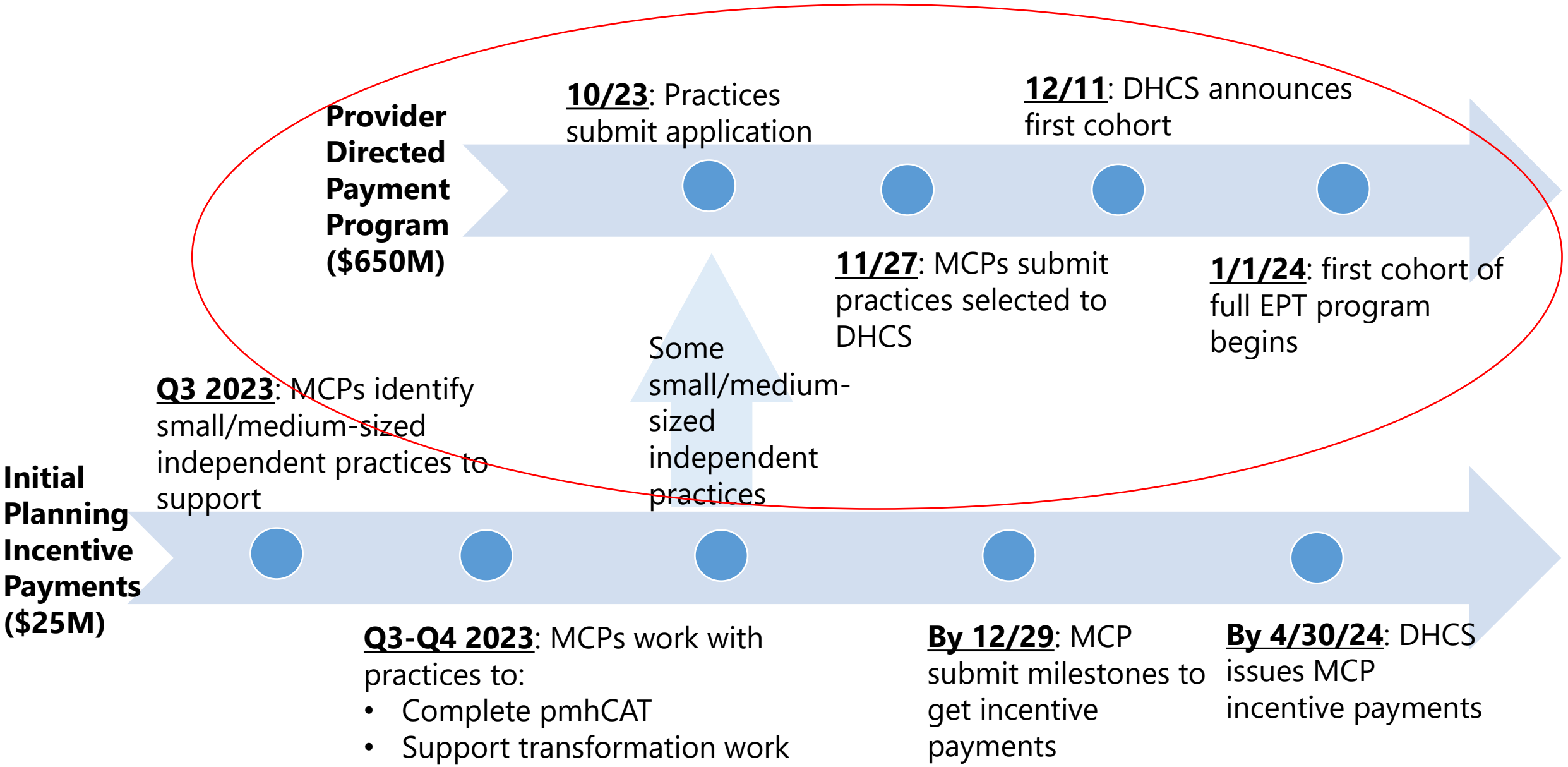
Timelines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Application

- **Application instructions will be posted to EPT website this week**; instructions will list out all the questions that will be on the web-based application (will be shared in near future)
- **Application due by October 23, 2023 at 11:59 pm** from primary care practice (must be completed by someone with signing authority)
- By applying to this program, **practices will be prospectively committing to specific activities**
- **Primary care practices of any size or type can apply**
  - Include IPAs and CINs working with primary care practices
  - Includes behavioral health providers working in an integrated primary care setting
  - Must be contracted with a Medi-Cal MCP

Population Health Management Initiative (PHMI)

- Program that **supports 32 Federally Qualified Health Centers' (FQHCs) work on population health management and health equity**
- PHMI has **developed resources to support clinics' transformation efforts**, many of which will be leveraged for EPT
- Many EPT activities are designed to be **consistent with PHMI Implementation Guides**

https://phminitiative.com/about/

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)

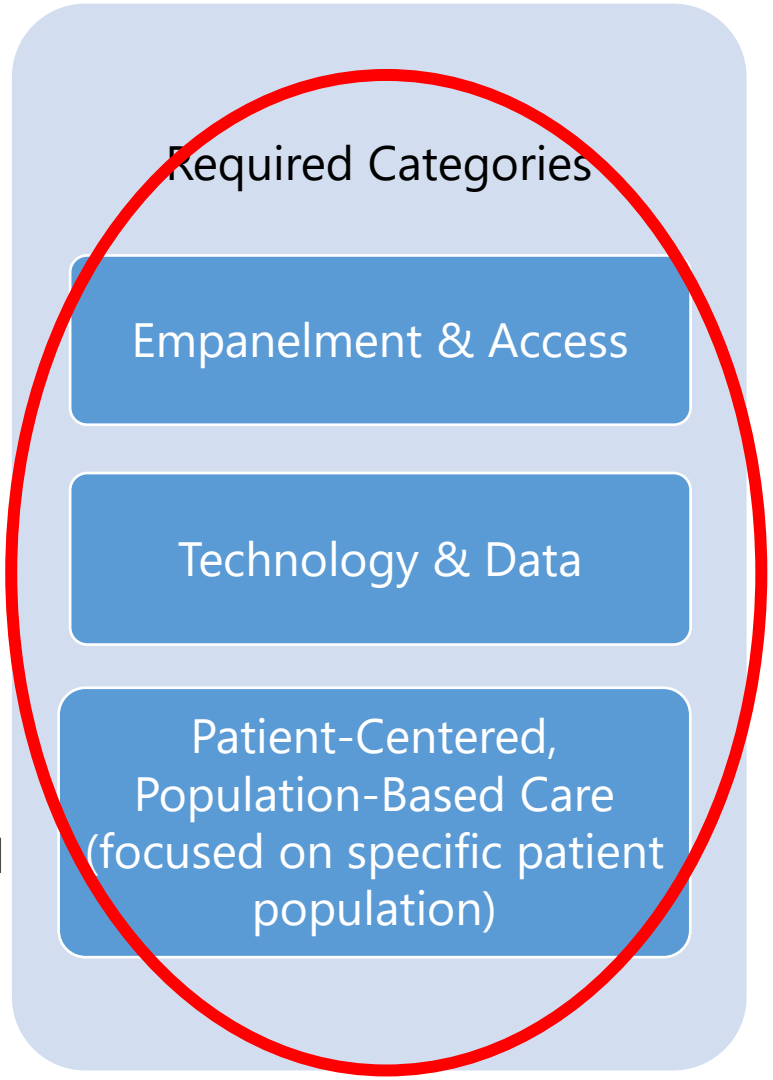
- Evidenced-Based Models of Care
- Value-Based Care & Alternative Payment Methodologies
- Leadership & Culture
- Behavioral Health
- Social Health

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

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



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

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**

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)

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

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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Category & Activities

Activity #1	**GOAL: X**
Activity #2	**GOAL: Y**
Activity #3	**GOAL: Z**

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

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

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

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

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

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+

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

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

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

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

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

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

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

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

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

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

Next Steps

DHCS Next Steps

- **Post application instructions to the EPT website**
- **Share the web-based application** with interested practices
- Work with stakeholders **to refine exact milestones and deliverables for each activity** (likely complete early Q4 2023); current materials only list "example steps"
- **Develop MCP guidance** for Provider Directed Payment Program before 10/23/23 (due date for applications):
  - Working to develop MCP guidance for types of applicants to prioritize for evaluation by DHCS
  - Goal is to select a variety of practices based on geography, size, type of practice, current level with practice transformation (more and less advanced practices), and populations served
- Working to **establish mechanism for practice to report milestone achievement and frequency of payments** from DHCS
- **Submit "preprint" to CMS for approval** before end of 2023

Practice Next Steps

- **Review program materials at EPT website**, including Guidelines and Application Instructions (to be posted this week)
- **Consider application to the program**, choosing a single MCP that the practice *will be contracted with in 2024* (even if practice crosses multiple counties)
- **Submit application** by October 23, 2023 at 11:59 pm
- **Contact MCPs with questions or email ept@dhcs.ca.gov**

MCP Next Steps

- **Continue to work with small- to medium-sized independent practices through the Initial Planning Incentive Payment Program**, with goal of getting practices to apply for Provider Directed Payment Program
- **Reach out to practices that might be good applicants** for Provider Directed Payment Program
- **Communicate with practices that reach out** about applying through your MCP for the Provider Directed Payment Program
- **Attend upcoming webinar with DHCS** to discuss programs in more depth; invite forthcoming soon

Questions?

https://www.dhcs.ca.gov/qphm/pages/eptprogram.aspx

ept@dhcs.ca.gov

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