Equity and Practice Transformation (EPT) Payment Program

Guidance for Primary Care Practices and Medi-Cal Managed Care Plans

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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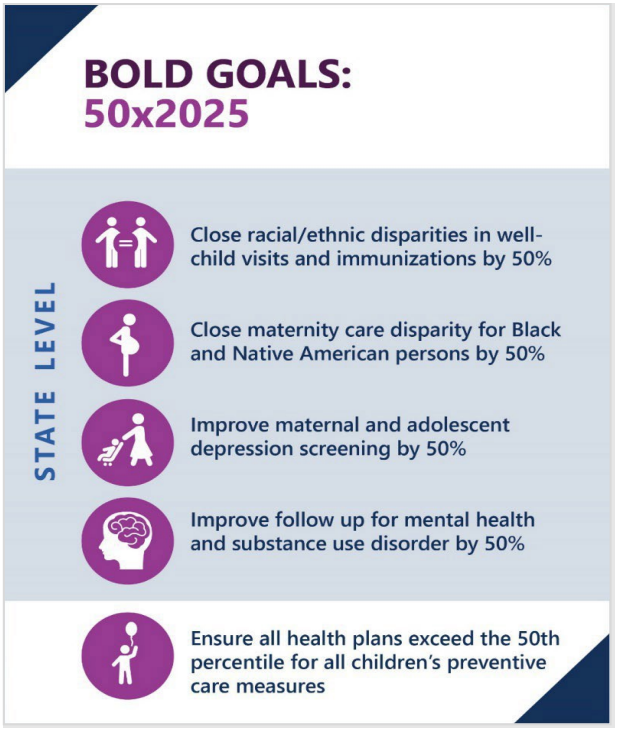
BACKGROUND

During the COVID-19 Public Health Emergency (PHE) DHCS has seen a significant reduction of preventive and routine chronic condition care, which disproportionately affected low-income communities of color. Furthermore, 55 percent of school-aged children are enrolled in Medi-Cal, 50 percent of the state's births are in Medi-Cal, and 68 percent of the Medi-Cal population is Black, Latino or people of color. As COVID-19 laid bare, the communities most affected by COVID-19 were often in most dire need of investments, health care access, and infrastructure. The Department is implementing a one-time $700 million ($350 million General Fund) initiative to advance equity, reduce COVID-19-driven care disparities, invest in up-stream care models and partnerships to address health and wellness and fund practice transformation aligned with value-based payment models to allow Medi-Cal providers to better serve the state's diverse Medi-Cal enrollee population.

To align with the goals of the DHCS Comprehensive Quality Strategy and Equity Roadmap, these funds will pay for delivery system transformation payments to primary care pediatric, family medicine, internal medicine, OB/GYN, and behavioral health providers focused on advancing DHCS' equity goals in the "50 by 2025: Bold Goals" Initiative and to prepare them to participate in alternative payment models.



These funds will include funding for a state-wide learning collaborative to support implementation and share best practices, as well as Initial Planning Incentive Payments and Provider Directed Payment Program payments.

BRIEF OVERVIEW OF PROGRAMS

Initial Planning Incentive Payments

($25 million over 1 year)

This program allows Medi-Cal Managed Care Plans (MCPs) to identify and work with primary care small- to medium-sized independent practices (not associated with a health care system) using a standardized assessment tool (https:/phminitiative.com/phmcat/) to support those practices as they develop Provider Directed Payment Program plans and applications. MCPs will earn incentive payments by supporting primary care practices in various preparation activities, including but not limited to the following: funding for staff time to prepare the program application and hiring a consultant to assist the practice in conducting a needs assessment, which may include assisting with research, tools, strategies, and other activities related to completing the program application. Initial Planning Incentive Payments will be paid to MCPs based on achievement of specific milestones and activities.

Provider Directed Payment Program

($650 million over 5 years)

This program supports delivery system transformation, specifically targeting primary care practices of any size that provide pediatric, family medicine, internal medicine, primary care OB/GYN services, or behavioral health integrated into primary care to Medi-Cal members. Recognizing the wide variation in primary care infrastructure, capacity, and ability to pursue a value-based payment, DHCS envisions a multi-year primary care transformation process that begins with foundational infrastructure investments and over the course of the program, scales evidence-based models of team-based care and prepares practices to assume risk-bearing contracts or join existing state alternative payment model demonstrations. Applicants must prospectively commit to specific activities and milestones, and funding will be disbursed based upon achievement of these activities and milestones. Additionally, all participants must complete a standardized assessment tool (https:/phminitiative.com/phmcat/) and review the results.

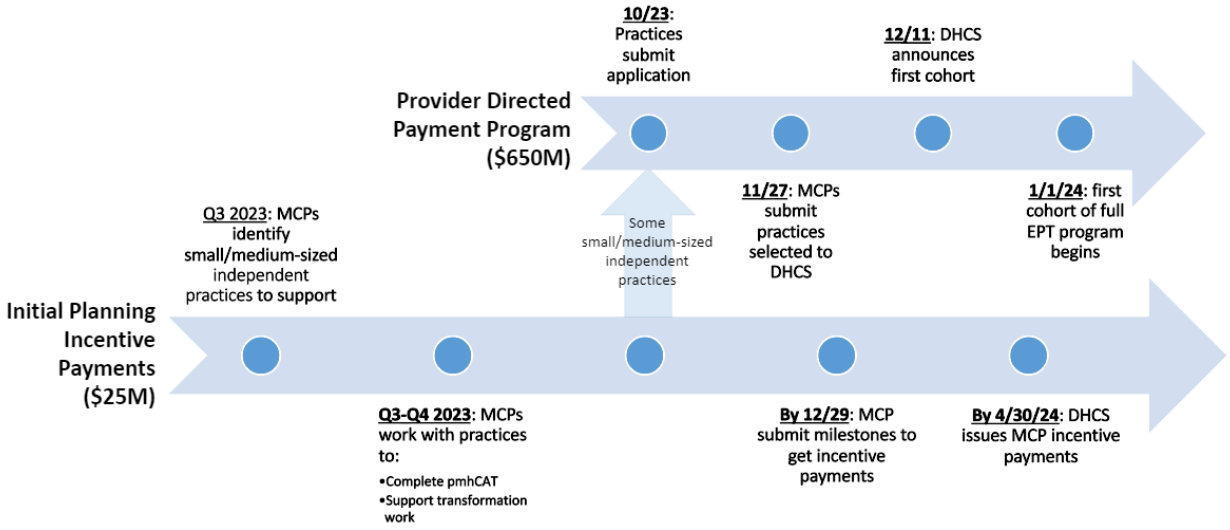
Statewide Learning Collaborative

($25 million over 5 years)

This program will support practices in the Provider Directed Payment Program in implementation of practice transformation activities, sharing and spread of best

practices, practice coaching activities, and achievement of stated quality and equity goals. Different tracks will be created for different pathways. Participation in the learning collaborative is a requirement for all participants in the Provider Directed Payment Program.

Timelines for Programs



INITIAL PLANNING INCENTIVE PAYMENT PROGRAM

This document provides guidance on basic requirements and recommendations for MCPs that are participating in these Initial Planning Incentive Payments and the practices with which they are partnering on future equity and practice transformation activities. MCPs can earn Initial Planning Incentive Payments for assisting small- to medium-sized independent practices with the necessary initial preparatory work that will result in a formal application for the Equity and Practice Transformation (EPT) Provider Directed Payment Program. MCPs can support each practice by providing funds for new or existing staff time to prepare the application and/or the hiring of a consultant to help the practice conduct a needs assessment and assist with research, tools, strategies, and recommendations to include in the development of their action plan/proposal and with completing the EPT Provider Directed Payment Program application.

Eligibility for this program is listed in *Appendix A – Eligibility by Program*.

MCP and Practice Engagement

Practices should approach a contracted MCP to learn more about how to prepare for the Provider Directed Payment Program. The primary MCP will be responsible for meeting applicable milestones to earn the incentive payments, including oversight and coordination with providers for purposes of this program. DHCS does not require an application or other documentation from either MCPs or practices to participate in this program.

MCP Reporting Requirements

MCP-level milestones for the Initial Planning Incentive Payments can be found in *Appendix B – MCP-level milestones to be reported for Initial Planning Incentive Payments*. To be eligible for payments, MCPs are required to report the milestones to DHCS after completion of the Provider Directed Payment Program application review/selection process and submission of all necessary milestone reporting, no later than December 29, 2023. DHCS will provide MCPs with the reporting template on which they will submit their data and instructions for submission once provider participants have been approved and communicated to DHCS.

Payment will be made to MCPs upon DHCS approval of the submitted MCP reporting template. Milestone values reported to DHCS must be true and accurate to the best of

the MCP's knowledge and must be a non-zero numerical value. DHCS expects to make payments to MCPs by April 30, 2024.

Achievement of milestones will be tied to 100% of the total allocation for the MCP upon formal review and approval by DHCS.

PROVIDER DIRECTED PAYMENT PROGRAM

This document will provide guidance on basic requirements and processes for practices interested in participating. Eligibility for this program is listed in *Appendix A – Eligibility by Program*. The program will start on January 1, 2024 and continue through December 31, 2028. All accepted practices must participate in the State-wide Learning Collaborative.

This program is a directed payment program, which means DHCS will direct MCPs to make specific payments to practices that qualify for payments. Directed payment programs are a CMS approved payment methodology to providers contracted under Medicaid managed care (see 42 CFR 438.6).

Applications

To be considered for this program, primary care practices must apply through the web-based application which can be requested by emailing ept@dhcs.ca.gov. DHCS recommends, but does not require, that practices complete the pmhCAT (https:/phminitiative.com/phmcat/) prior to applying. This tool will help practices identify areas for improvement in the Provider Directed Payment Program.

Applications are due on October 23, 2023 at 11:59 pm. MCPs will review applications from October 23, 2023 to November 27, 2023; by the end of November 27, 2023, MCPs will submit to DHCS those applications they recommend for approval by DHCS. DHCS will then review applications and announce selected practices on December 11, 2023. In reviewing applications, DHCS will prioritize practices from areas with HPI quartile 1 or 2.

Funding

All aspects of funds distribution are subject to CMS approval given this program includes a federal drawdown. Achievement of activities/milestones is a requirement of CMS, and funding cannot be provided upfront prior to achievement of activities/milestones. The frequency of activity/milestone reporting to DHCS, the means of submission to DHCS, and the frequency of payments to practices are still being determined. Funding per practice is divided proportionally to the number of activities (e.g. if the practice is accepted into the program for 10 activities, then each activity would be allocated 1/10 of the approved funding).

The maximum amount of payments a practice may receive is based on the number of assigned Medi-Cal (inclusive of D-SNP) members under an active Medi-Cal Managed Care Plan contract at the time of application. 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. Maximum amounts may be reduced by DHCS based on the number of activities selected. The practice cannot receive funding in this program for an activity already paid for by federal funds. Federally Qualified Health Centers in the Population Health Management Initiative (PHMI) may not apply for activities already covered in that program. The maximum payment amounts are listed in the table below.

Number of Assigned Medi-Cal (including D-SNP) Members at Time of Application	Maximum Payment
500-1,000	$375,000
1,001-2,000	$600,000
2,001-5,000	$1,00,000
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 or more	$10,000,000

Practice Expectations

Practices must prospectively commit to activities in the application, and payment will be made based on achievement (including proof when requested by DHCS) of committed activities/milestones.

Some activities are required, and practices must either commit to these activities or attest that they have already fully completed these activities. The activities are listed in *Appendix C – Categories, Activities, and Example Milestones for Provider Directed Payment Program*. Periodic meetings between the practices and DHCS (or its contractors) will be required to assess progress toward completing activities; additionally, practices and MCPs are encouraged to meet as needed to support completion of activities.

Appendix C – Practice Expectations for Provider Direct Payment Program shows an overview of practice requirements for the Provider Directed Payment Program.

Categories, Activities, and Example Steps

All activities for this program are grouped into three "required" and five "other" (optional) categories. Each activity has example steps to give a practice a sense of the types they might work on; the actual milestones for financial payments are still being developed and are anticipated in Q4 2024. The categories, activities, and example steps are listed in *Appendix C – Categories, Activities, and Example Steps for Provider Directed Payment Program*.

For each activity in two of the required categories ("Empanelment & Access" and "Data & Technology"), the practice (1) must commit to the activity, or (2) attest to prior completion of the activity. DHCS chose required activities because completion of these activities increases a practice's ability to be successful in other areas. If a practice has already completed a required activity but determines they still want to do further work, they may still voluntarily choose to commit to an activity (e.g. practice recently upgraded to a new EHR but would like to move to a better EHR). However, Federally Qualified Health Centers in the Population Health Management Initiative (PHMI) may not apply for activities already covered in that program (the application reviews what PHMI participants may and may not apply for).

For the required category is "Patient-Centered, Population-Based Care", each practice must commit to working with a focus population on all the activities in this category. The focus populations are limited to:

- Pregnant people (prenatal care and up to 12 months postpartum)
- Children and youth
- Adults with preventive care needs
- Adults with chronic conditions
- People living behavioral health conditions

All practices must also commit to working with a further subpopulation of the larger focus population. The practice will be expected to focus on this subpopulation approximately 2-3 years into the program. The work with this subpopulation will involve refining care delivery team and health equity efforts to better the subpopulation's needs. The subpopulation must be chosen from the list below:

- Transitions from incarceration
- People experiencing homelessness
- Adults at risk of needing or receiving long-term care placement services

- People living behavioral health conditions including substance use disorders (this subpopulation should not be chosen if the focus population is "people living behavioral health conditions")
- Populations experiencing disparities because of race/ethnicity
- Foster youth
- Individuals who identify are LGBTQ+

MCP Expectations

MCPs should work with practices in this program to support them in completing activities/milestones. Many activities/milestones will require strong partnership with MCPs. Partnership may involve (but is not limited to) data exchange, process changes, leadership engagement, in-kind technical assistance from the MCP, and/or financial support (which is at the discretion of each MCP).

Statewide Learning Collaborative

Participation in this program is required of all practices in the Provider Directed Payment Program. The timing of these collaboratives is still being determined, but required formal meetings will be no more often than 2-3 hours once a month.

APPENDIX A – ELIGIBILITY BY PROGRAM

Practice Eligibility Criteria	Initial Planning Incentive Payments	Provider Directed Payment Program
Contracted Medi-Cal Managed Care Plan practice	Required	Required
Primary care practice	Required	Required
50 or few providers	Required	Optional, no size limits
Not associated with a healthcare system*	Required	-
Serve at least 1,000 assigned Medi-Cal members (or 500 for rural providers)	Required	Required
Can Clinically Integrated Networks and Independent Provider Associations be part of program	No	Yes, can apply if work with primary care
Disproportionately serve Black/African American, Alaska Native/Native American, or LGBTQ+ patient population**	Recommended	Recommended
Tribal health programs, Rural Health Clinics, or other rural practices†	Recommended	Recommended
Performance on key measures <50th percentile	Recommended	-
Located in Health Places Index Quartile 1 areas	Recommended	Recommended
Practices not otherwise receiving funding for the same activities in the Cal-AIM Incentive Payment Program (IPP) or the PATH TA Marketplace program or the Data Exchange Framework (DxF) Grant Program	Recommended	Practices cannot receive funding for activities already paid for by federal funds

*Wholly owned, governed, and/or operated by any of the following: Designated Public Hospitals (DPHs), county operated healthcare systems, Level I or II trauma centers, FQHCs (with the exception of tribal health programs or Rural Health Centers), and/or Cost-Based Reimbursement Clinics

**DHCS is not providing an exact definition for "disproportionately"

†Tribal health programs and "Rural Health Centers" may include (1) all tribal health programs broadly, (2) rural FQHCs (thus an exception to the FQHC exclusion), and/or (3) practices located in rural areas

APPENDIX B – MCP-LEVEL MILESTONES TO BE REPORTED FOR INITIAL PLANNING INCENTIVE PAYMENTS

Milestone	Metric
Complete the standardized provider readiness assessment tool	• Number of small- to medium-sized independent practices that completed the provider readiness tool (https:/phminitiative.com/phmcat/) and shared results with the MCP (MCPs to provide data from small- to medium-sized independent practices' surveys in format specified by DHCS)
Submit an Equity and Practice Transformation Provider Directed Payment program formal application	• Number of small- to medium-sized independent practices that submitted an Equity and Practice Transformation Provider Directed Payment Program application • Enhanced funding for percentage of EPT applications from small- to medium-sized independent practices located in Healthy Places Index Quartile 1

APPENDIX C – CATEGORIES, ACTIVITIES, AND EXAMPLE STEPS FOR PROVIDER DIRECTED PAYMENT PROGRAM

Required Categories	Other Categories (Optional)
Empanelment & Access	Evidence-Based Models of Care
Technology & Data	Value-Based Care & Alternative Payment Methodologies
Patient-Centered, Population-Based Care	Leadership & Culture
	Behavioral Health
	Social Health

Categories	Activities	Example Steps

Empanelment & Access	**Empanelment & Access:** 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.	• Implement an empanelment methodology including policies and procedures and standard operating procedure in place that support empanelment.
		• Develop key empanelment Key Performance Indicators (KPIs) to support panel management to include metrics for continuity, access, provider capacity, and attribution discrepancies.
		• Evaluate fidelity to policies and procedures and achieving below goals of KPI metrics at least yearly
		  ○ Ensure 90% of attributed patients (both those assigned by MCP and those attributed by practice process) are assigned to a PCP at the practice
		  ○ Achieve continuity such that 70% of attributed/assigned patient visits are with their assigned PCP

Technology & Data	**Data Governance for Population Health:** Develop and implement a formal structure for population health and quality improvement including regular meetings of key practices stakeholders whom relevant data and develop/implement strategies to improve population health and quality.	• Create a data governance workgroup charter which defines goals, structure, participants, and key decision makers • Use data governance workgroup to construct metrics including defining data elements, benchmarks, and method to review metrics and update as required with industry standards. • Develop ongoing evaluation of data governance process and outcomes. • Identify specific areas of the organization that will monitor these metrics to understand performance and initiate quality improvement efforts.

	Dashboard & Business Intelligence: 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 stakeholder using business analytics tools (e.g. Excel, Power BI, Tableau, Arcadia, or another similar tool).	• Develop KPIs including selection of key domains (i.e., utilization, financial performance, quality metrics etc.). Identify appropriate metrics to stratify by race, ethnicity, sexual orientation, gender identify and other factors to identify disparities. • Assess capabilities of current technology and tools to produce KPIs. Identify any gaps in capability to produce KPI, and build and execute a plan to address (e.g., purchase new tool, upgrade current tool/s etc.). • Implement a standard process and structure for distributing KPI report to monitor organizational performance and to gather feedback on opportunities for improvement and successes. • Demonstrate how KPI metrics are integrated into organizational goals and team performance.
	Data and Quality Reporting Gaps: Determine, create a strategy, and implement a formal strategy to address gaps in data that's 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.	• Assess organizational KPI data gaps including internal data integrity and external data acquisition (e.g., HEDIS metric, enrollment, claims, encounter, other KP metrics etc.). • Create a workplan to address each data gap identified with specific goals and timeframes. Identify barriers to addressing data gaps that organization is unable to solve for. • Report progress on closing data gaps annually.
	New/Upgraded Electronic Health Record (EHR), and/or Population Health Management Tool: 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.	• Conduct formal written analysis of the gaps in functionality of the current EHR and/or population health tools. • Solicit formal bids for new EHR/population health management (PHM) tool or upgrade to existing her/PHM tool to address the gaps in functionality. • Implement new/upgraded software/tool. • Document ability of the new software/tool to improve gaps in PHM functionality as documented through a regularly administered review.
	Data Exchange: 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.	• Solicit a formal bid for implementation of DxF-qualifying HIO (must include bidirectional data transmission). • Execute contract for HIO. • Establish HIO integration with existing EHR and other health information technology (HIT). • Demonstrate use cases of HIO data for individual patient care and other PHM activities.
Patient-Centered, Population-Based Care	**Care Team Design and Staffing** 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.	• Determine core care team model incorporating population health management functions and roles. • Conduct assessment of current core care team to identify gaps in functions and roles.

		• Create a plan to implement new core care team model to address gaps including those identified for population health management function and roles. • Implement plan for new core care team model. • Evaluate impact of core care team design on patient satisfaction, provider satisfaction, operational efficiency, and Bold/MCAS measures. • Build strategy to source (i.e., hire new staff, redeploy existing staff, retraining existing staff etc.) new care team roles with consideration of financial and other impacts. • Implement strategy to source new care team roles (i.e., post positions and hire new staff, initiate retraining etc.). • Evaluate effectiveness of hiring and retention efforts to sustain new care team model.
	Stratification to Identify Disparities: 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.	• Stratify Bold Goals/MCAS measure/s by socioeconomic variables (race, ethnicity, sexual orientation, gender identify etc.). • Create a formal plan to address identified disparities. This should include a root cause analysis, patient, provider, and community feedback, and process to monitor and adjust plan as needed. • Implement the disparities reduction plan. • Evaluate the disparities reduction plan at least annually.
	Clinical Guidelines: Choose and implement evidence-based clinical guidelines.	• Select clinical guidelines that impact chosen population of focus. • Implement clinical guidelines including communication of guidelines to staff, adapt workflows based on clinical guidelines for patients seen in clinic and patients not seen in clinic. • Develop and implement approach to monitor adherence to clinical guidelines and report results annually.
	Implement Condition-Specific Registries: Create, implement, and use condition-specific registries.	• Build and implement technology plan to create and utilize a registry. May require purchase of tool. • Develop SOPs, workflows, and identify staff to support registry. • Implement registry. • Complete formal written evaluation of registry use including process measures and impacts on Bold Gold/MCAS measures annually.
	Proactive Patient Outreach and Engagement: Create and implement a formal strategy to better engage and outreach to patients, including patients assigned by not seen	• Perform an analysis of the current state of patient outreach to the selected population of focus. This should include the assigned but unseen population as well as a review of outreach activities stratified by key demographics (e.g. race, ethnicity, sexual orientation, gender identify, etc.). • Develop a patient engagement strategy that includes patient feedback and preferences and incorporates attention to identified disparities.

		• Implement patient engagement strategy. • Evaluate engagement strategy including effectiveness of the approach to engaging the assigned but unseen as well as engaging those populations with identified disparities.
	Pre-visit Planning and Care Gap Reduction: Create and implement a formal process for pre-visit planning (that at minimum addresses gaps in care)	• Conduct analysis of current pre-visit planning process and develop an approach that includes the following elements: use of standing orders, daily huddles, and method to identify open care gaps. • Implement, refine, and revise pre-visit planning process to optimize effectiveness. • Evaluate pre-visit planning approach including impact on care gap closure.
	Care Coordination: Create and implement a formal strategy to address care coordination needs for patients with more complex health and social needs.	• Determine strategy to identify patients with care coordination needs (this may be formal risk stratification or other method to identify patients with additional care needs). • Apply risk stratification methodology to selected population of focus, at a minimum. • Develop and implement care coordination services. Will include identifying services needed, identifying/hiring staffing resources, training, and may include technology acquisition or revision to support and enable care coordination services. • Evaluate impact of care coordination strategy including impact on Bold Gold/MCAS measures.
Evidence-Based Models of Care	**New/Expanded Care Delivery Model:** Choose and implement an evidenced-based model for focus population (e.g. Dyadic Care, Doulas, Centering pregnancy, group visits for conditions like diabetes, Project Dulce, collaborative care model for behavioral health, remove monitoring for patients with hypertension, Medication Assisted Treatment, etc.).	• Develop evidenced-based model that is co-designed by feedback from patients, providers, and care teams evidenced by policies/procedures (or equivalent) and key findings from co-design. • Develop business case for new care delivery model and understand impact on practice revenue and cost. • Define key measures and track. Should include and not be limited to bold goal and MCAS measures (link measures). • Implement care delivery model. • Scale model to reach 80% of patients within the population of focus. • Demonstrate that model improved Bold Goals/MCAS measures. that map to the care delivery model/selected population of focus.
Value-Based Care & Alternative Payment Methodologies	**FQHC APM**: 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).	• Conduct Assessment of APM readiness (including PHMI business case tool, PhmCAT, any available DHCS readiness checklists, and additional deep dives into financial, data, operational, clinical gaps as needed). • Identify gaps with 12-month action plan with technical assistance from established experts in collaboration with MCP(s).

		• Completion of action plan with re-assessment of APM readiness demonstrating no critical gaps in collaboration with MCP(s). • Application submitted for FQHC APM. • Entry into FQHC APM once accepted.
	Value-Based Payment: 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).	• Conduct assessment of value-based payment readiness (PhmCAT and additional financial, data, operational, clinical domains). • Identify gaps with 12-month action plan with technical assistance from established experts and discuss results with MCP(s). • Establish value-based contracting model with one or more Medi-Cal MCPs, may range from quality adjusted primary care capitation to total cost of care upside only or up and downside risk, joining ACO or CIN model for a specific population of patients, or other HCP-LAN category 3 or 4 contracting arrangement. • Address identified gaps in value-based payment readiness assessment, develop necessary infrastructure to succeed in value based contracting arrangement with Medi-Cal MCP(s). • Pass MCP readiness review and/or pre-delegation audit for value-based contract. • Initiate value-based contract for 12-month period or longer. • Evaluate performance in value-based contract with MCP and assess future contract terms.
Leadership and Culture	**DEI Strategy:** Create and implement an organizational-wide strategy to work on diversity, equity, and inclusion (DEI).	• Develop a DEI framework, approach, and goals for practice, with support from experts and input from practice staff, patients and community served consistent with best practice. • Develop and document a formal DEI plan, including how it relates to the overall strategic plan for the practice and define quantitative and qualitative measures of success and achieving goals. • Implement formal DEI plan and monitor adoption, barriers and adjustments to be made. • Evaluate DEI plan on annual 12-month cycle, incorporating feedback from stakeholders including practice staff, patients and community members as well as reporting on results of quantitative and qualitative measures and achievement of goals.
	Strategic Planning: 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).	• Define key elements of strategic plan (which should be for a minimum of three years), including but not limited to the following: mission/vision/values, landscape assessment, internal analysis (e.g. SWOT), strategic direction to reach vision for future state, clear goals and objectives (must cover at minimum DEI/health equity, patient and community partnership/engagement, patient access, quality, workforce satisfaction and retention, and value-based care), activities that the practice will undertake to reach goals and objectives over the period of the strategic plan

		• Incorporate and document clear process for obtaining stakeholder feedback on strategic plan – including frontline staff, management, patients, and community members. • Write and publish strategic plan, including communication of plan with all stakeholders. • Implement strategic plan and monitor progress toward goals and objectives at minimum annually through written report to stakeholders.
	Patient and Community Partnership/Engagement: 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.).	• Develop and document a strategy for patient and community engagement that is informed by patients and community members, evidence-based and best practices, and specific health goals and priorities set by the communities served by the practice. Obtain direct feedback on the strategy from patient and community members as well as practice staff. • Define and document specific actions to be taken to enhance patient and community engagement, including SMART goals and activities that will be implemented to achieve goals. • Implement patient and community engagement activities and monitor progress towards goals and objectives at minimum annually through written reports. • Evaluate effectiveness of specific actions/activities in achieving goals through feedback from patients, community members and practice staff annually.
Behavioral Health	**Behavioral Health Integration (BHI) in Primary Care** Integrate behavioral health into primary care practice to provide more comprehensive care for patients.	*NOTE: Medication Assisted Treatment (MAT) may be the model of care chosen in "New/Expanded Care Delivery Model", which is an optional activity. Primary care-based MAT does not necessarily require full behavioral health integration (as medications are prescribed through primary care); however, a practice may decide to implement integrated behavioral to strengthen its MAT program.* • Define behavioral health (BH) screening approach for the practice, including: specific tools/questions to be used for mental health and substance use screening, patient populations that will be screened, frequency of screening, screening data capture and reporting mechanism, protocol for triage of patients based on screening results and linkage to appropriate level of behavioral health services (e.g. provider, peer counselor, group, county services, crisis intervention services, etc). • Define key operational and quality metrics to monitor progress and determine effectiveness of BH screening.

		• Develop and document required operational workflows and EHR/HIT system modifications to support behavioral health screening.
		• Implement behavioral health screening strategy and report at minimum quarterly on implementation progress, including percent of population screened and linkage to behavioral health services.
		• Select evidence-based model for integrating behavioral health services into primary care, such as the Collaborative Care Model, Behavioral Health Consultant Model, or other approaches integrating key evidence-based activities for BHI that include:
		  ○ Screening for depression, anxiety, and other behavioral disorders using validated screening tools.
		  ○ Team-based care with non-physician staff to support primary care physicians (PCPs) and comanage treatment.
		  ○ Shared information systems that facilitate coordination and communication across providers.
		  ○ Standardized use of evidence-based guidelines.
		  ○ Systematic review and measurement of patient outcomes using registries and patient tracking tools.
		  ○ Engagement with broader community services.
		  ○ Individualized, person-centered care that incorporates family members and caregivers into the treatment plan.
		• Define key operational and quality metrics to monitor progress and determine impact of BHI model.
		• Implement evidence-based model for behavioral health integration, including activities outlined and committed to by practice in optional "Expanded/New Care Delivery Model" activity and required "Care Team Design and Staffing" activity
		• Evaluate impact of BHI model on key metrics at 12 months post implementation, and then annually with written report

Social Health	**Social Needs/Risk Screening and Intervention:** Create and implement a formal process for screening for and intervening on patients' social needs/risks	• Develop a social needs screening and intervention strategy for the practice that includes documented activities, workflows and procedures that support the key elements of social health integration into primary care as outlined in the National Academy of Sciences • Set specific goals, objectives, and timeframes for each element of the 4 As outlined as in the National Academy of Sciences framework. Monitor and report on progress annually. • Exchange social health data with local CIE/HI and Managed care plans. • Complete written evaluation of implementation of social needs screening and intervention strategy annually, including number of

		patients screened and linked to services annually, progress toward practice specific goals and objectives, and key barriers and learnings during the implementation process.

APPENDIX D – PRACTICE EXPECTATIONS FOR PROVIDER DIRECT PAYMENT PROGRAM

	Required	Optional
Primary Care Practice (including integrated behavioral health)	X	
Choose focus population (and subpopulation) and evidence-based model of care to implement	X	
Funding Limit Based on Assigned Lives	X	
Web-based Application due by 10/23/23 at 11:59 pm	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 activities or attest to previous completion	X	
Practice cannot receive funding for activities already paid for with federal funds	X	
Complete pmhCAT	Will be required in 2024 for practices accepted, including meeting to review results	Recommended before completing application
Applying for funding in area beyond required categories and activities		X