Department of Health Care Services

Equity & Practice Transformation (EPT) Frequently Asked Questions (FAQ)

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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CLARIFICATION OF TERMS

1. **What is considered "*associated with a health care system*"?**
   "Associated with a health care system" means wholly owned, governed, and/or operated by any of the following:
   i. Designated Public Hospitals (DPHs),
   ii. County operated healthcare systems
   iii. Level I or II trauma centers
   iv. Federally Qualified Health Centers (not including Indian Health Services or rural practices as defined below in question #3), and/or
   v. Cost-Based Reimbursement Clinics

2. **What is the definition of an independent practice?**
   "Independent" is defined as a practice that does not meet the above definition defined in the above definition of a practice "associated with a health care system".

3. **How are "Indian Health Services" and rural practices defined?**
   Indian Health Services are defined as tribal health programs broadly and rural practices may include (1) Rural Health Centers (as designated by CMS), (2) FQHCs in rural areas (thus an exception to the FQHC exclusion), and/or (3) practices located in rural areas.

INITIAL PLANNING INCENTIVE PAYMENTS

1. **Is there a limit to the number of practices a Medi-Cal Managed Care Plan (MCP) can work with for the EPT program?**
   There is no limit to the number of practices an MCP can work with.

2. **What is the frequency of the incentive payments to the MCPs?**
   There will be one-time incentive payments issued to MCPs that meet specified metrics/milestones.

3. **What is the allocation model that will be used for the incentive payments?**
   The allocation model for the incentive payments to MCPs has not yet been finalized. Note, MCPs earn incentive payments for meeting metrics/milestones and actual payments will be based on each MCP's performance.

4. **Will MCPs share incentive payments with their contracted practices?**
   MCPs will earn incentive payments for meeting metrics/milestones. Once an MCP earns EPT incentive payments, DHCS does not direct or restrict the MCP's use of these funds.

5. **What type of provider will be included in the provider count for a practice's eligibility to for the Initial Planning Incentive Payments?**
   For the 1-50 provider count, any Medi-Cal billable provider counts (e.g. physician, NP, PA, LCSW, psychologist, dentist, etc.). Dental-only practices cannot be targeted for support in this program. The overall practice must meet the criteria outlined even if diverse provider types are included in the provider count.

6. **What is the threshold that will determine how the recommended disproportionate population focus will be evaluated?**
   There is no set threshold (meaning each MCP can determine the threshold) for defining the definition for "serves disproportionate numbers of Black/African American, Alaska Native/Native American, or LGBTQ+ populations compared to county demographics".

PROVIDER DIRECTED PAYMENT PROGRAM

1. **Can a practice be accepted into the program on an individual basis and as part of an Independent Provider Association (IPA)/Clinically Integrated Network (CIN)?**
   No. A practice can only be accepted to the program through an individual application or through an IPA/CIN application. Practices should communicate with any IPA/CIN they are part of to determine which entity applies to the program. Not all practices in an IPA/CIN must participate in the IPA's/CIN's application (e.g. a subset of the practices might decide to support an IPA/CIN application); practices not participating in their IPA's/CIN's application may apply independently. An IPA/CIN that applies must indicate which practices they are representing. If an IPA/CIN applies indicating it represents a practice and the practice also applies, DHCS will ask one of the parties to withdraw or modify their applications to prevent the overlapping applications; if neither withdraws or modifies their application, both applications will be denied. IPAs/CINs may not retain any payments that are directed to network providers through this program; all directed payments must be received by the participating practices. If an IPA/CIN is applying, then every practice that is a part of the IPA's/CIN's application must submit a letter of support by October 23rd, 2023 at 11:59 pm (can be individual letters or joint letters). The template for that letter of support is below.

   To whom it may concern at DHCS:

   My practice, [practice legal name], is a member of [IPA or CIN]. I support [IPA's or CIN's] application to the Provider Directed Payment Program on our behalf. We are not submitting our own application to the Provider Directed Payment Program. I have reviewed all the requirements of the Provider Directed Payment Program. I agree to commit our practice to all necessary investments of time, staff, and resources to work on the activities that the [IPA or CIN] is applying for on our behalf.

   [Signature by individual with signing authority for the practice]

2. **If a practice does not have direct contracts with MCPs but rather contracts through an IPA and/or CIN, can the practice apply to the program?**

a. Yes. Practices may apply through an IPA, CIN, or similar structure if they have a demonstrable "unbroken contracting path" between the MCP and the provider for applicable date(s) of service. An "unbroken contracting path" means a sequence of contracts linking an MCP to the provider, either directly or through a subcontractor or a series of subcontractors.

3. **What types of organizations can apply as an umbrella of practices (e.g. IPA, CINs, ACOs, FQHC consortia, medical groups)?**
    a. IPAs/CINs can apply as listed above in questions #1 and #2. If a Medical Group provides the same services as an IPA, then they may apply as an IPA as long as questions #1 and #2 are addressed. Other types of umbrella organizations may also apply if they meet the criteria in questions #1 and #2.
4. **Can practices with less than 500 Medi-Cal assigned lives at the time of application apply?**
    a. No.
5. **How should practices decide which MCP to apply through?**
    a. While the practice chooses which MCP through which to apply, DHCS recommends MCPs and practices determine the best pairings based on contracting status, working relationship, existing collaborative plans, and future collaborative plans. Strong partnership between the practice and MCP will enable the practice to be more successful in the program.
6. **Which MCP should a practice apply through if there are only new MCP(s) in their county starting in January 2024?**
    a. It is suggested the practice applies through one of the newly entering MCPs (with which you expect to be contracted with if a contract is not yet in place). This approach will ensure the practice is considered through the most appropriate MCP that will be operating during the duration of the program.
7. **Do MCPs receive any administrative funds for this program?**
    a. Any consideration of administrative funds would be considered separate and apart from this program.
8. **For practices paid through PPS, do these payments affect Medi-Cal reconciliation?**
    a. Payments in the Provider Directed Payment Program are not subject to annual Medi-Cal PPS reconciliation. MCPs must, and practices are urged to, keep track of payments for audit purposes (e.g. in general ledger).
9. **What are the allowable costs for this program?**

a. This program is not a grant program, thus the concept of "allowable costs" does not apply. Practices may use earned funds in the program as they see fit, including to support any and all activities needed to achieve the milestones for this program (e.g. hiring practice coaches to support transformation or procuring a new technology solution).

10. **What do the Medi-Cal assigned lives (used to determine maximum payments) refer to? Do they refer to the practice's overall assigned lives or the focus population? Do they refer to all lives even if only some practice sites are participating in the program?**
    a. Assigned lives refer to overall Medi-Cal (inclusive of D-SNP) assigned lives across all contracted MCPs, across all participating sites, and across all counties. Do not include assigned lives for sites not participating (for example, if only one site out of five sites is participating, then only include assigned lives for the one site). Do not included assigned lives for any other payors beyond Medi-Cal (inclusive of D-SNP). Do not include fee for service Medi-Cal patients (i.e. those without an MCP).
11. **If a patient has primary insurance which is not Medi-Cal (e.g. private insurance or Medicare) and has Medi-Cal as secondary, is that patient part of the Medi-Cal assigned lives count?**
    a. If the practice is the assigned PCP for the Medi-Cal MCP, then these patients can be counted.
12. **Can a practice include the number of lives they expect to have in the future (for example, they are expecting to be contracted with a new MCP in the future or they are acquiring another practice soon after the due date for this application)?**
    a. No.
13. **Can a practice that is in multiple counties apply through MCPs in multiple counties?**
    a. No. Each single legal entity (which runs the practice) can only apply once.
14. **Can a larger organization with multiple clinic sites have each of those sites apply to the program separately?**
    a. Each legal entity may only apply to the program one time. If the overall larger organization is a single legal entity which directly operates all the clinic sites, then only a single application may be submitted.
15. **Do all activities/milestones need to be completed in 2024?**
    a. No. This is a five-year program. Pending CMS approvals, practices may have up to five years to complete activities/milestones for payment.

However, there may be requirements around a minimum number of milestones that must be completed per year; details on this will be released in the future.

16. **Should a practice attest to a particular required activity if that activity has only been partially completed in the past or the practice believes it needs to do additional work to be more successful?**
    a. No. Partial completion is not sufficient for attestation. Practices that have not fully addressed the required activities must commit to completing these required activities in the program.
17. **Will there be another cohort for this program?**
    a. Another cohort may occur but given that this program is funded with one-time funding only, it is uncertain how much funding will remain for a future cohort. We encourage all practice interested to apply in this cohort to have the best change at being selected.
18. **If a practice indicates in their application that they have already previously completed an activity, can they receive a payment for that activity in this program?**
    a. No. Payments will only be made for activities and milestones completed during the program period.
19. **If a practice is part of Population Health Management Initiative (PHMI), can they apply for this program?**
    a. Yes, but there are limitations to what activities practices can choose (which are covered on the first page of the application). The maximum payment in the Provider Directed Payment Program is not different for PHMI vs. non-PHMI practices.
20. **What is the cadence of payments in this program?**
    a. Payments to practices will likely be twice a year as determined by DHCS. Due dates for milestones and activity completion, in order to qualify for payments, will be released by DHCS at a later time.
21. **What if a practice participates in another program that has the same or similar activities as EPT. Can they still apply for this program and/or specific activities?**
    a. Practices that participated in the CalAIM Incentive Payment Program (IPP) or the Path TA Marketplace Program may still apply for EPT activities if they did not receive funding to specifically address those activities which they are planning to complete as a part of EPT. Practices that receive or the DSA Signatory Grant Program (through the Data Exchange Framework

(DxF)) may apply for any activities in the Provider Directed Payment Program even if there is overlapping funding.

22. **What qualifies for "integrated behavioral health" to potentially apply to the program?**
    a. Integrated behavioral health must include behavioral health clinicians providing direct behavioral health services (whether in-person, through telehealth, or via e-consults) to the patients of a primary care practice, including warm handoffs. The behavioral health services must meet all stated requirements of the activity and example steps/milestones for "Behavioral Health Integration (BHI) in Primary Care". Please note that simply referring to offsite behavioral health would not be sufficient.
23. **Are payments taxable?**
    a. DHCS cannot provide advice or guidance on taxes.
24. **Can a practice add new locations to the program after January 2024, e.g. if the practice acquires new sites?**
    a. No, unless the practice applies for those locations to be included in a future cohort of this program.
25. **Can a practice change activities later based on unexpected changes in patient population or practices needs?**
    a. Any consideration of changes would be case-by-case and at DHCS's discretion.
26. **How will practices submit information about milestone and activity completion during the program?**
    a. This process is still being determined.
27. **What is the structure of the learning collaborative?**
    a. This is still being determined.
28. **Can a practice change their sub-population of focus after the beginning of the program?**
    a. Practices will not be allowed to routinely change their sub-population. On a case-by-case basis and at its sole discretion, DHCS will consider changes to the practice's sub-population when provided with justification.