Provider Directed Payment Program
Frequently Asked Questions

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Funding Acceptance

Will provider organizations receive confirmation from DHCS when they send their acceptance for participating in the Provider Directed Payment Program (PDPP)?

DHCS notified Partnership that all awarded provider organizations have submitted confirmation that they plan to participate in the PDPP. See appendix A for a list of participating provider organizations.

Will there be a second cohort? If so, when will the application period begin, and who is eligible to participate?

Due to the budget revisions set by Gov. Gavin Newsom in May 2024, there will not be a second cohort.

How can I get a copy of the application our provider organization submitted?

Please email ept@dhcs.ca.gov to request a copy of your application.

Milestones and Deliverables

Do all milestones need to be completed in 2024?

Due to revisions to the FY 24/25 state budget, Equity and Practice Transformation Program (EPT) is now a three year program. All 2024 milestone deliverables will need to be completed by 2025. Pop Health Learning Center (PHLC) is still developing what milestone achievement will look like in 2025 and 2026.

What is the difference between a milestone and a deliverable?

Milestones are utilized to monitor practice progress and capacity building, and deliverables enable practices to demonstrate evidence of milestone achievement. Completed deliverables are also the catalyst for directed payments. PHLC will provide practices with templates for all deliverables either via email and/or their Milestones and Deliverables webpage.

Where can I find the updated list of EPT milestones?

The updated list of final EPT milestones can be found here and on PHLC's Milestones and Deliverables webpage.

Will EPT providers be held accountable for all HEDIS-like measures?

Provider organizations are to focus on the one (1) population of focus identified on their Provider

Directed Payment Program application submitted in October 2023. Please reach out to ept@dhcs.ca.gov if you are unsure of your population of focus.

Will managed care plans (MCPs) have visibility into the deliverables submitted by the provider organizations?

Yes.

If the submitted activities are not deemed sufficient to meet the requirements, how will this be handled?

After each submission (May 1 and November 1), PHLC will review the deliverables and provide specific feedback to the provider organization if any are insufficient.

What criteria will PHLC use to evaluate the deliverables?

PHLC will be providing technical assistance to assist provider organizations in meeting milestones and preparing deliverables. Deliverable templates will be provided as well, to provide clear guidance on the requirements. All available templates are posted on PHLC's Milestones and Deliverables webpage.

We are a one provider community clinic and only have one person identified for our EPT core team, can we still participate?

Yes, in that case, you can have one person participate in the Technical Assistance activities and events.

Can we get help or guidance through a website without purchasing the optional coaching services?

Yes! You may participate in all of the Technical Assistance opportunities listed below without purchasing coaching. PHLC offers optional coaching as an add-on service.

- View learning modules on PopHealth+, PHLC's eLearning hub. If you need login credentials, email info@pophealthlc.org for access.
- Attend the quarterly Learning Community Sessions that cover specific EPT Building Blocks.
- Participate in bi-monthly Practice Track meetings to share best practices, successes, and challenges. To learn your Practice Track, email PracticeTransformation@partnershiphp.org or info@pophealthlc.org.
- Partnership has assigned an EPT coach to each of their sponsored practices, please reach out to PracticeTransformation@partnershiphp.org to get connected.

What denominator population should be used for Key Performance Indicator (KPI) reports?

Denominators can be based on all patients or just Medi-Cal only patients.

Payments

How will activity payments be structured?

DHCS will determine milestones and award amounts. PDPP funding will be issued to Partnership who will then be responsible for distributing payments to each provider organization.

What is the cadence of payments and how will payments be structured?

There will be two payment cycles each year. Deliverables will be submitted by May 1 with payments to provider organizations anticipated in October of the same year. Deliverables submitted November 1 should see payments to provider organizations in April of the following year.

Payment Cycle	Practice Submits Deliverable(s)	Learning Center Completes Review of Deliverable(s)	DHCS Operationalizes Payments	MCPs Receive Payments	Estimated MPC Payments to Providers (Practices)
Fall	May 1	May 31	June - August	September	October
Spring	November 1	November 30	December - February	March	April

Will the value of each milestone fluctuate?

The payment amount for each milestone will remain constant.

Are payments taxable?

DHCS, PHLC, and Partnership cannot provide advice or guidance on taxes.

What if a provider organization fails to meet a milestone?

The provider organization may be subject to removal from the Equity and Practice Transformation program if milestones are not met. After the July 2024 revisions to the EPT program, all milestone deliverables were deemed required.

What are the allowable costs for this program?

This program is not a grant program, thus the concept of “allowable costs” does not apply.

Provider organizations 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 coaches to support transformation or procuring a new technology solution).

Will provider organizations be required to submit financial reports or expense documentation for the payments received?

No, since this is not a grant program, the concept of allowable costs does not exist. Once you earn the money, as long as it is legal, you can spend that money as you see fit. DHCS recommends reinvesting the money in the care provided to your patients.

Do the payments received through EPT have an impact on capitation payments?

These directed payments should not affect your usual capitation payments.

If a provider organization reaches certain milestones or completes activities prior to EPT rollout, can reimbursement be retroactive?

Directed payments do not allow for retroactive reimbursement. Directed payment programs can only pay for activities that take place during the EPT program period.

What happens if provider organizations are added to a platform or the number of members changes during the course of the EPT program?

The maximum allowable payment is determined by the information provided at the time of application. The maximum allowable payment will not increase or decrease during the program timeframe. Due to the recent state budget revisions, the revised maximum potential payment each practice is eligible for is published on PHLC's webpage here.

Is the maximum payment amount evenly distributed across all three years?

Yes, the payment for all 25 required milestone deliverables are evenly distributed across the program's three-year span. If your organization is participating in PHMI, you are only eligible to submit 23 required milestones.

Participation in the Program

Does participating in the program change anything in regards to how providers see and treat patients?

Participating in EPT will not change the current way providers are being reimbursed for seeing and treating patients.

Can a provider organization add new locations to the program (e.g. if the provider organization acquires new sites)?

No.

Can a provider organization change their sub-population of focus after the beginning of the program?

No.

PhmCAT

How do we submit the PhmCAT?

Providers can go to http://www.takethephmcat.com to complete the deliverable.

Who within our organization needs to complete the PhmCAT?

PHLC is requiring all provider organizations to submit at least three separate PhmCAT survey submissions from the following roles: Provider, Clinic front-line (e.g. MA or Nurse), and an Administrative/Office Manager. For larger provider organizations, submit up to five additional PhmCAT surveys from the following roles: Executive Sponsor (e.g. CEO, COO), Clinical lead (e.g. CMO, CNO, Medical Director), Finance lead (e.g. CFO, accounting manager), Data & tech lead (e.g. CIO, IT director), and a Quality lead (e.g. quality manager/director).

Should we average our results from all of the individuals and submit only one PhmCAT?

PHLC would like each designated individual to complete the PhmCAT on their own. PHLC will evaluate the submissions and provide an aggregated report in mid-May, that will guide subsequent support throughout this program.

We have multiple sites across our organization, do we need to complete the PhmCAT for each location?

No. Each provider organization is only required to submit between three and eight surveys in total, to reflect all sites participating in the program. See previous question “Who within our organization needs to complete the PhmCAT” for additional information.

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Coaching

What Technical Assistance coaching resources are available?

PHLC has three different Coaching Pool Packages with varying coaching focuses, time commitment, and cost. For more information, please email info@pophealthlc.org.

When will Technical Assistance coaching begin?

The Optional Coaching Services from PHLC have begun. Partnership has assigned an EPT coach to each of their sponsored practices at no additional cost. They can connect you to resources, provide input on policies related to EPT milestones, workflows, and deliverables. They can also provide training on quality improvement tools and project management support on deliverables and EPT activities.

Can a provider organization choose to hire coaches on their own, outside of the coaching pool?

Yes, though there may be benefits to working through the coaching pool to decrease costs and ensure consistency.

Is coaching optional and how will the cost be covered?

Provider organizations may choose to engage with the coaching pool, which will be trained and vetted by PHLC. The cost of this coaching may be covered through funds received by completing milestones, foundations, and other philanthropy groups. The coaching pool is not funded by DHCS or PHLC.

Other Frequently Asked Questions

Where can we send any additional questions?
You can email questions to Partnership at PracticeTransformation@partnershiphp.org
You can email questions to DHCS at EPT@DHCS.ca.gov.
You can email questions to PHLC at info@pophealthlc.org.
We recommend cc'ing Partnership in your emails to DHCS and/or PHLC for visibility and support.

Where can I learn more about the Population Health Learning Center?
You can learn more about the Population Health Learning Center at https://pophealthlearningcenter.org/

Will provider organizations receive login access to the PopHealth+ portal?
PHLC provided login information to PopHealth+, please email info@pophealthlc.org if you need access.

My email address has changed, how can I update this with PHLC?
Please email your request to info@pophealthlc.org to update the listserv.

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Appendix

Accepted for EPT Funding (27 Provider Organizations)

*Some provider organizations applied for sites located across multiple counties as listed.

County	Provider Organization
Del Norte	Stallant Health and Wellness
Del Norte, Humboldt	Open Door Community Health Centers
	United Indian Health Services
Humboldt	Kima:w Medical Center
	Southern Humboldt Community Clinic
Lassen	Lassen Indian Health Center
	Northeastern Rural Health Clinics
Lassen, Modoc, Shasta	Pit River Health Service
Lassen, Shasta, Siskiyou	Mountain Valleys Health Centers
Shasta	Shasta Community Health Center
Siskiyou	Fairchild Medical Center
Shasta, Tehama	Dignity Health – Lassen Medical Clinic
Marin, Sonoma	Petaluma Health Center
Mendocino	Baechtel Creek Medical Clinic
	Redwood Coast Medical Services
	Round Valley Indian Health Center
Mendocino, Sonoma	Sonoma County Indian Health Project
Solano	Solano County Family Health Services
Sonoma	Alexander Valley Healthcare
	West County Health Centers
Colusa, Butte, Glenn, Sutter, Tehama, Yuba	Ampla Health
Butte, Glenn, Tehama, Yolo	Northern Valley Indian Health
Butte, Sacramento, Sutter, Yuba	Peach Tree Health
Nevada, Placer	Chapa-De Indian Health Program
Nevada, Placer, Sierra, Yuba	Western Sierra Medical Clinic
Plumas, Sierra	Eastern Plumas Health Care
Sutter, Yuba	Harmony Health Medical Clinic

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Categories, Milestones for Provider Directed Payment Program

Required Categories
Population Health Management Capabilities Assessment (PhmCAT)
Empanelment and Access
Data to Enable Population Health Management
Care Delivery Model
Value Based Payment (VBP)
Key Performance Indicators (KPI)

Categories	Milestone	Deliverable
Population Health Management Capabilities (PhmCAT)	1. PmhCAT submission for year one 2. PmhCAT submission for year two 3. PmhCAT submission for year three	Assessment
Empanelment and Access	1. Empanelment assessment: Assess current empanelment environment including understanding of baseline data on percent of patients who are empaneled to a provider/care team, continuity based on current assignment, and third next available appointment.	Assessment and baseline data
	2. Empanelment policy and procedure: Develop and implement a standard policy and procedure that addresses the method of assigning patients to care team panels, changing assignments, maintaining panel size and continuity, and monitoring empanelment effectiveness.	Policy and procedure
Data to Enable Population Health Management	1. Data governance and HEDIS reporting assessment: Develop a data governance policy and procedure and assess how the practice is accessing, using, managing, sharing, reporting, and integrating data from external sources that are required to produce KPIs for the selected population.	Policy and procedure and assessment

Categories	Milestone	Deliverable
Data to Enable Population Health Management, cont.	2. Data implementation plan: Develop implementation plan for addressing data and technology gaps and transforming practice operations to support development of KPIs. Plan must include steps for implementing these three strategies: a. Identifying and outreaching to the assigned but unseen population b. Using gaps in care reports that include practice and MCP data c. Data exchange with two external partners, at least one of which is a Qualified Health Information Organization (QHIO)	Implementation Plan
	3. Progress report on implementing data improvement strategies: Demonstrate evidence of implementing at least three strategies from the data implementation plan including: a. Identifying and outreaching to the assigned but unseen population b. Using gaps in care reports that include practice and MCP data c. Data exchange with two external partners, at least one of which is a Qualified Health Information Organization (QHIO)	Progress Report
Care Delivery Model	1. Develop plan to reduce disparity: Develop and implement a plan to reduce a disparity in at least one HEDIS-like metric related to the population of focus; plan should include feedback and participation from staff and patients or community partners	Implementation Plan
	2. Adopt clinical guidelines: Adopt evidenced-based clinical guideline(s) related to KPI metrics for selected population of focus. Monitor adherence to guideline(s) for providers to ensure standardization in practice. This includes communication of guidelines to staff, adapting workflows based on clinical guidelines for patients seen and not seen in clinic, integration of guidelines into the EHR, and tracking provider/care team adherence to guidelines.	Clinical guideline(s) and report on guideline adherence
	3. Care team assessment and implementation: Assess current core and expanded care team roles to identify gaps in functions and roles needed to manage the population of focus. Identify and implement new core and expanded care team model to address identified gaps.	Assessment and implementation plan

Categories	Milestone	Deliverable
Care Delivery Model, cont.	4. Implement enhanced outreach and engagement: Develop and implement outreach strategy for population of focus to ensure access to evidence-based care using clinical guidelines and to address disparities. This should include review of reports of patients assigned but not seen and patients with care gaps, development of workflows, and identification and training of care team members to do the work	Implementation plan
	5. Implement Pre-visit planning: Implement pre-visit planning for scheduled patient care for population of focus to reduce disparities and improve receipt of evidence-based care using clinical guidelines. This should include development of workflows, including how patient-level health maintenance reports are reviewed and utilized, and identification and training of care team members to do the work.	Workflow
	6. Implement behavioral health screening & linkage: Implement depression screening and follow-up using the PHQ-2/PHQ-9 and substance use disorder (SUD) screening and linkage. This should include development of workflows for what staff member screens and how often, how data is stored in the health record, protocol for triage of patients based on screening results, and linkage to appropriate level of behavioral health services with closed loop referrals. Demonstrate how processes are working through a report of the following: a. Depression screening i. Percent of population of focus screened with PHQ-2/PHQ-9 (80% target) ii. Percent of patients with positive screening who are linked to services (80% target) iii. Percent of patients linked to services with a close looped referral b. b. SUD screening i. Percent of population of focus screened for SUD (80% target) ii. Percent of positive SUD screens linked to services (80% target) iii. Percent of patients linked to services with a close looped referral	Workflow and metric reporting

Categories	Milestone	Deliverable
Care Delivery Model, cont.	7. Health-related social needs (HRSN) screening & linkage: Identify one health-related social need for the population of focus and implement screening process and linkage to care with closed loop referrals. This should include development of workflows for who screens and how often, how data is stored in the health record (includes EHR capture of social health Z codes), protocol for triage of patients based on screening results, and linkage to services with closed loop referrals. Demonstrate how processes are working through a report of the following: a. HRSN screening i. Percent of population of focus screened for HRSN (80% target) ii. Percent of patients with positive HRSN screening who are linked to services (80% target) iii. Percent of patients linked to services with a closed looped referral	Workflow and metric reporting
Value Based Payment (VBP)	1. VBP assessment: Conduct assessment of value-based payment readiness, identify gaps, and develop an action plan in coordination with the MCP.	Assessment
Key Performance Indicators (KPI)	1. Stratify HEDIS-like measures: Submit KPI report that includes HEDIS-like measures applicable to the selected population of focus stratified by race and ethnicity and at least one additional characteristic: primary spoken language, sexual orientation, gender identity, housing status, or disability.	KPI report
	2. Population of Focus HEDIS-like achievement #1: Demonstrate improvement or meet target in one population of focus HEDIS-like measure; achievement must be sustained over two consecutive submissions or met in the final submission.	KPI report
	3. Population of Focus HEDIS-like achievement #2: Demonstrate improvement or meet target in a second population of focus HEDIS-like measure; achievement must be sustained over two consecutive submissions or met in the final submission.	KPI report
	4. Population of Focus HEDIS-like achievement #3: Demonstrate improvement or meet target in third population of focus HEDIS-like measure; achievement must be sustained over two consecutive submissions or met in the final submission.	KPI report
	5. Empanelment achievement: Achieve target for the percent of attributed patients (both those assigned by MCP and those attributed by practice process) who are assigned to a care team at the practice; achievement must be sustained over two consecutive submissions or met in the final submission.	KPI report

Categories	Milestone	Deliverable
Key Performance Indicators (KPI)	6. Continuity achievement: Achieve target for the percent of attributed/assigned patient visits with their assigned care team; achievement must be sustained over two consecutive submissions or met in the final submission.	KPI report
	7. Third next available achievement: Achieve target for number of days to third next available appointment; achievement must be sustained over two consecutive submissions or met in the final submission.	KPI report
	8. Assigned and seen in 12-month period: Achieve improvement threshold for the percent of patients assigned and seen in a 12-month period; improvement must be sustained over two consecutive submissions or met in the final submission.	KPI report
	9. Disparity reduction: Demonstrate improvement in at least one disparity identified in the reported HEDIS-like measures; improvement must be sustained over two consecutive submissions or met in the final submission.	KPI report

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Final Equity and Practice Transformation (EPT) Key Performance Indicators (KPI)

KPI	Measure Type	Population of Focus	Stratify*
Prenatal and Postpartum Care (PPC) - Postpartum Care	HEDIS-Like	Pregnant	Yes
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care	HEDIS-Like	Pregnant	Yes
Postpartum Depression Screening and Follow-up (PDS-E)	HEDIS-Like	Pregnant	Yes
Child Immunization Status (CIS)	HEDIS-Like	Child/Youth	Yes
Well Child Visits in First 30 Months of Life (W30)	HEDIS-Like		Yes
Child and Adolescent Well-Care Visits (WCV)	HEDIS-Like		Yes
Colorectal Cancer Screening (COL)	HEDIS-Like	Adult Preventive	Yes
Breast Cancer Screening (BCS)	HEDIS-Like		Yes
Cervical Cancer Screening (CCS)	HEDIS-Like		Yes
Controlling High Blood Pressure (CBP)	HEDIS-Like	Adult Chronic Care	Yes
Glycemic Status Assessment for Patients with DM >9% (GSD)	HEDIS-Like		Yes
Depression Screening and Follow-Up for Adolescents and Adults (DSF)	HEDIS-Like	All Except Pregnant	Yes
Depression Remission or Response for Adolescents and Adults (DRR)	HEDIS-Like	Behavioral Health	Yes
Pharmacotherapy for Opioid Use Disorder (POD)	HEDIS-Like	Behavioral Health	Yes
Empaneled Patients	Administrative	All	No
Patient-Side Continuity	Administrative	All	No
Third Next Available Appointment	Administrative	All	No
Assigned Patients Seen in a 12-Month Period	Administrative	All	No

**Stratify by race and ethnicity and at least one additional characteristic.*

Key Performance Indicators (KPI) Performance Goals for KPI Milestones

KPI	Improvement Threshold	Attainment Target
For Each HEDIS-Like Measure**	If starting above the 75th percentile, 5% gap closure towards the 90th percentile -OR- If starting below the 75th percentile, 15% gap closure towards the 75th percentile	If at or above the 90th percentile, maintain performance
Empaneled Patients	N/A	≥ 90% target
Patient-Side Continuity	N/A	≥70% target
Third Next Available Appointment	N/A	≤ 10 days target
Assigned Patients Seen in a 12-Month Period	10% improvement from baseline	N/A

***Milestones related to performance on HEDIS-like KPIs can be met by achieving either the improvement threshold or the attainment target. Where percentiles are referenced, these refer to NCQA Medicaid HEDIS benchmarks.*