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?

DHCS anticipates a second cohort with similar content to be announced at a future date. Those who were not selected for the first cohort are encourage to reapply for the second cohort. However, those who participated in the first cohort are ineligible to apply again as this will ensure opportunities are available for other provider organizations to participate.

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.

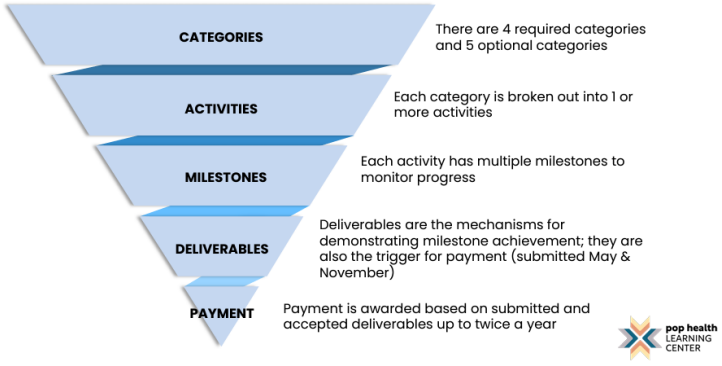
Activities/Milestones

Do all activities/milestones need to be completed in 2024?

No, the PDPP is a five-year program. Pending CMS approval, provider organizations may have up to five (5) years to complete activities/milestones for payment. However, there may be requirements around a minimum number of milestones that must be completed per year. More information is expected to come from PHLC soon.

What is the difference between a milestone and an activity?

The program is designed with each activity having multiple milestones to help gauge progress. The pyramid below shows the differences between each component.



Can provider organizations change their required or optional activities later based on unexpected changes in the provider organization's needs?

As a general practice, changes to the selected activities is not permitted. Any consideration of changes would be case-by-case and at DHCS' discretion.

Are the categories and activities listed under Appendix C all the required activities providers must complete?

DHCS confirmed *Appendix C* from the *EPT Guidance for Primary Care Practices and Medi-Cal Managed Care Plans* is out of date as of January 2024. Please reference the *Final EPT Activities and Milestones* document for the most current information regarding PDPP.

For the required activity, "Patient-Centered, Population-Based Care" do providers use the focus population selected on the application only, or for all five (5) populations listed?

Provider organizations are to use only one (1) focus population and one (1) subpopulation for the "Patient-Centered, Population-Based Care" activity.

When is the first deliverable due and when can we expect to receive the payment?

The first activity will be to complete the PmhCAT; this deliverable is due no later than April 30 at 11:59 pm. Payments for this activity will be distributed to provider organizations in October 2024.

When will the reporting platform be available for the submissions?

The Population Health Learning Center (PHLC) will share information on the eLearning platform as it is put into place over the summer. The initial deliverable of a completed PhmCAT will be captured through the automated system on the PHLC website, www.takethephmcat.com.

Can provider organizations get credit for completing milestones related to optional activities before completing all required activities?

Provider organizations are asked to complete and submit all required activities before submitting the optional activities. PHLC is currently developing the deliverables template and submission platform.

If a provider organization is in the process of completing milestones and activities before their due dates, can these be considered deliverables?

Any milestones completed after January 1, 2024 can be used for deliverables, but work completed prior to that date cannot.

When will the deliverable templates be available for the required and optional activities?

PHLC is developing the deliverable template and submission platform, and will notify all EPT participants once it is made available.

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, 2024 and November 1, 2024), PHLC will review the deliverables and provide specific feedback to the provider organization if any are insufficient.

When will planned deliverables be due?

The first deliverable of the completed PhmCAT must be submitted no later than 11:59 pm on April 30, 2024. PHLC will provide a suggested sequence for the activities, but provider organizations may determine their own timetable for all other required deliverables.

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 what is required. Templates will be provided once they are available.

What is the DxF agreement? And will all provider organizations be required to sign it?

Information on the DxF agreement, including who is required to sign it, can be found on https://dxf.chhs.ca.gov/for-participants/#how-to-sign-the-dsa .

My organization has not signed the data sharing agreement, can we still participate if the agreement has not been signed?

More information on the DxF agreement will be released in the future. Many types of provider organizations are required to sign the DxF agreement; we recommend provider organizations determine if this is required.

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Payments

Will the maximum payment amount for each provider organization be the same as the amount on the original submission?

All provider organizations can receive up to the maximum amount they applied for. DHCS has posted the list of accepted provider organizations with their maximum potential payment here.

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 (2) payment cycles each year. Deliverables will be submitted by May 1, 2024 with payments to provider organizations anticipated in October 2024. Deliverables submitted November 1, 2024 should see payments to provider organizations in April 2025.

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 after the weighted value of the PmhCAT is determined for the first year.

Are payments taxable?

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

What if a provider organization fails to meet a milestone?

If the provider organization fails to meet a milestone they will not receive payment for that activity. There are no additional consequences. DHCS has clarified that this is not a grant, it is a directed payment program – the payment is for completing one of the required or optional activities within the timeframe.

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 provide 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.

Is the maximum payment amount evenly distributed across the 5 years, or can a provider organization complete all milestones before the end of the 5 years to receive the full amount?

Technically a provider organization can complete the milestones prior to the end of the program, however due to CMS Approval/Budget constraints some dollars may have to shift to another fiscal and/or program period.

Participation in the Program

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

Participating in PDPP 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, unless the provider organization applies for those locations to be included in a future cohort of this program, should one become available.

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

Provider organizations will not be allowed to routinely change their sub-population. On a case- by-case basis, DHCS will consider changes to the provider organization's sub-population when provided with justification.

What happens if a provider cannot fulfill the requirements of the program?

There are no other consequences apart from not receiving funding. There is no penalty to organizations approved for PDPP funding, but do not achieve all the milestones.

PhmCAT

How do we submit the PhmCAT for the April 30, 2024 deadline?

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

Our provider organization submitted the PhmCAT during the application phase, do we need to complete this activity again?

Some provider organizations may have completed the PhmCAT as part of the application phase. For those provider organizations, we ask that you review your answers to make sure they are still accurate and then submit the PhmCAT again to serve as the April 30 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 question “Who within our organization needs to complete the PhmCAT” for additional information.

Coaching

When will information about the TA coaching pool be available?

This is still in development. PHLC will release details as soon as this information is available on their website.

When will TA coaching begin?

The DHCS timeline indicates this will begin around the time the first directed payments are received in October 2024.

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 the coaching curriculum available?

PHLC is currently developing the coaching curriculum and will release details as soon as this information is available on their website.

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, Managed Care Plan sponsorship, foundations and other philanthropy groups. The coaching pool is not funded by DHCS or PHLC.

Are Managed Care Plans required to pay for the coaching pool?

No, they can be a potential sponsor.

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?
https://pophealthlearningcenter.org/

Will provider organizations receive login access to the PHLC portal?
PHLC will provide provider organizations with access to the eLearning Platform when it becomes available.

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

Appendix

Accepted for PDPP 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, Activities, and Milestones for Provider Directed Payment Program

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

Categories	Activities	Milestones (must be completed in order)
Practice Transformation Assessment	**PmhCAT Completion:** Completion of the PhmCAT each year is required for ongoing participation in the program.	1. PmhCAT submission for year 1 2. PmhCAT submission for year 2 3. PmhCAT submission for year 3 4. PmhCAT submission for year 4 5. PmhCAT submission for year 5
Empanelment and Access	**Empanelment and 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). Note: “care team” is used instead of PCP to acknowledge the collaborative nature of the team caring for a patient	1. Develop empanelment methodology and Key Performance Indicators (KPIs). a. Implement an empanelment methodology (including a formal operating procedure) that supports empanelment. b. Develop empanelment KPIs to support panel management. Include metrics for continuity, access, provider capacity, and mismatches in attribution, e.g. the patient is seeing care team other than their assigned care team. 2. At least one year after completion of the prior milestone, evaluate fidelity to operating procedure by reporting the following based on a single calendar year (CY) of data: a. 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 provider organization

Categories	Activities	Milestones (must be completed in order)
		b. The percent of attributed/assigned patient visits with their assigned care team c. Access measures trended over time 3. During a single CY, 90% of attributed patients (both those assigned by MCP and those attributed by practice process) are assigned to a care team at the provider organization 4. During a single CY, 70% of attributed/assigned patient visits are with their assigned care team.
Technology and Data	**Data Governance for Population Health:** Develop and implement a formal structure for population health and quality improvement, including regular meetings of key provider organization stakeholders who review data and develop/implement strategies to improve population health, healthcare quality, and health equity.	1. Create a data governance workgroup charter which defines goals, structure, participants, and key decision makers. 2. Use data governance workgroup to choose metrics including defining data elements, benchmarks/goals (which should be chosen based on provider organization's goals and payor expectations), and a method to review and update metrics. 3. Identify specific areas of the organization (e.g. specific teams or individuals) that will monitor these metrics to understand performance and initiate quality improvement efforts. 4. Develop and implement an ongoing evaluation of data governance process and outcomes; specifically, at least one year after prior milestone completion, create a report with the following information: a. Results of all initially chosen metrics b. Any proposed changes to the metric list c. A formal assessment that addresses: ○ Did the provider organization reach metric goals? If no, why not? ○ Does the provider organization need to adjust metric goals/benchmarks and why? ○ Does the provider organization need to add or remove metrics, and why? 5. One year after prior milestone completion, show improvement on at least 3 practice metrics.

Categories	Activities	Milestones (must be completed in order)
	Dashboard and Business Intelligence: Determine the provider organization'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).	1. 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/or other factors to identify disparities. 2. Assess capabilities of current technology and tools to produce KPIs. Identify any gaps in capability to produce KPIs and build and execute a plan to address (e.g., purchase new tool, upgrade current tool.) 3. Implement a standard process and structure for distributing KPI report to monitor organizational performance and to gather feedback on opportunities for improvement and successes. Report should be distributed to key internal (and external when appropriate) stakeholders. 4. Demonstrate how KPI metrics are integrated into organizational goals and team (e.g. employee and contractor) performance
	Data and Quality Reporting Gaps: 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.	1. Assess and report on organizational KPI data gaps including internal data integrity and external data acquisition (e.g., HEDIS metric, enrollment, claims, encounter, other KPI metrics etc.). 2. Create a work plan to address each data gap identified with specific goals and timeframes. Identify barriers to addressing data gaps that organization is unable to solve for. 3. Create formal report on progress to close data gaps at least one year after prior milestone. Set specific goals for improving data gaps over one year. 4. At least one year after the prior milestone is completed, show progress towards goals in closing specific data gaps.

Categories	Activities	Milestones (must be completed in order)
	Upgraded Electronic Health Record (EHR), and/or Population Health Management (PHM) Tool: Ensure the provider organization 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 provider organization has all the tools they deem necessary.	1. Conduct formal written analysis of the gaps in functionality of the current EHR and/or PHM tools. 2. Solicit formal bids for new EHR/PHM tool or upgrade to existing EHR/PHM tool to address the gaps in functionality. 3. Implement new/upgraded software/tool. 4. At least one year after prior milestone, show how the new software/tool addressed gaps in PHM functionality.
	Data Exchange: Establish, maintain, and use bilateral data feeds with a Data Exchange Framework (DxF) Qualifying Health Information Organization (QHIO), as defined by the current DxF framework and to be further defined in future DxF policies.	1. Formalize the costs of implementation of DxF-QHIO (must include bidirectional data transmission); for example, provider organization might obtain a formal bid from a DxF- QHIO vendor. 2. Execute contract for a DxF-QHIO. 3. Demonstrate bi-directional data exchange through the contracted DxF-QHIO. 4. At least one year after prior milestone, show at least two use cases of DxF-QHIO data being used to improve individual 5. patient care and other PHM activities.
Patient-Centered and 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.	1. Formally determine core care team model incorporating population health management functions and roles. 2. Conduct assessment of current core care team to identify gaps in functions and roles. 3. Create a plan to implement new core care team model to address gaps including those identified for population health management function and roles.

Categories	Activities	Milestones (must be completed in order)
		4. Implement plan for new core care team model with existing team members (if not possible, see milestone 6). 5. Evaluate impact of core care team design on KPIs or other metrics relevant to the care team model implemented. 6. 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. 7. Implement strategy to source new care team roles (i.e., post positions and hire new staff, initiate retraining etc.). 8. Evaluate effectiveness of hiring and retention efforts to sustain new care team model by showing improvement in KPIs/metrics in number 5 above.
	Stratification to Identify Disparities: Use data to stratify services and/or outcomes measures by variables that might demonstrate health disparities (e.g. race/ethnicity, sexual orientation/gender identity, etc.), and implement a strategy to decreases any disparities identified.	1. Stratify population of focus metrics and/or KPIs by demographic variables (race, ethnicity, sexual orientation, gender identity etc.). 2. 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. 3. Implement the disparities reduction plan. 4. At least one year after prior milestone, show improvement in population of focus metrics and evaluate implementation of the disparities reduction plan.

Categories	Activities	Milestones (must be completed in order)
	Clinical Guidelines: Choose and implement evidence-based clinical guidelines.	1. Select evidenced-based clinical guidelines that can improve the care for the chosen population of focus. 2. Implement clinical guidelines including communication of guidelines to staff, adapting workflows based on clinical guidelines for patients seen in clinic and patients not seen in clinic, and integration of workflows into the provider organization's EHR (where possible). 3. At least one year after the prior milestone, implement an approach to monitor adherence to clinical guidelines which includes examining clinical metrics and report results to stakeholders (which would include, at minimum, provider organization staff and leadership). 4. At least one year after number 3 above, show improvement in at least 2 clinical metrics tied to the implementation of clinical guidelines.
	Implement Condition-Specific Registries: Create, implement, and use condition-specific registries.	1. Build and implement technology plan to create and utilize a registry. May require purchase of tool. 2. Develop processes/workflows to use and identify which staff will use and maintain the registry. 3. Implement registry. 4. At least one year after the prior milestone, complete formal written evaluation of registry use including process measures and impacts on population of focus measures (e.g. but not limited to: HEDIS, utilization, and/or satisfaction metrics). 5. At least one year after number 4, show improvement in at least 2 population of focus measures tied to the implementation of condition-specific registries.

Categories	Activities	Milestones (must be completed in order)
	Proactive Patient Outreach and Engagement: Create and implement a formal strategy to better engage and outreach to patients, including patients assigned but not seen.	1. 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 (ideally stratified by key demographics, e.g. race, ethnicity, sexual orientation, gender identify, etc.). 2. Develop a patient engagement strategy that includes patient feedback, experience, and preferences and incorporates attention to identified disparities. 3. Implement patient engagement strategy. 4. At least one year after the prior milestone, evaluate engagement strategy including effectiveness of the approach to engaging the assigned but unseen as well as engaging those populations with identified disparities. This evaluation must report the annual percent of patients assigned but not seen, overall and at least one subpopulation with identified disparities. At least one year after the prior milestone, show improvement in report the annual percent of patients assigned but not seen, overall and at least one subpopulation with identified disparities.

Categories	Activities	Milestones (must be completed in order)
	Pre-visit Planning and Care Gap Reduction: Create and implement a formal process for pre-visit planning (that at minimum addresses gaps in care)	1. Conduct analysis of current pre-visit planning process and develop an approach that includes the following elements: use of standing orders, huddles, transitions of care data (which might include admission, discharge, and transfer (ADT) feeds), and method to identify open care gaps. 2. Implement, refine, and revise pre-visit planning process to optimize effectiveness. 3. One year after completion of the prior milestone, evaluate pre-visit planning approach including impact on care gap closure (e.g. HEDIS metrics). 4. At least one year after completion of the prior milestone, show improvement in at least 2 HEDIS metrics showing care gap closure.
	Care Coordination: Create and implement a formal strategy to address care coordination needs for patients with more complex health and health-related social needs.	1. Determine strategy to identify patients with care coordination needs, which must be a formal risk stratification method (that can be described and implemented consistently). The method can include any type of data that is relevant (including but not limited to diagnoses, utilization, staff report, etc.). Strategy should explicitly address transitions in care from one level of care to another (e.g. hospital discharge). 2. Apply risk stratification methodology to, at a minimum, selected population of focus. 3. Develop and implement care coordination services. Will include identifying services needed (whether internal or external), identifying/hiring any needed staffing resources, training, and any needed technology. 4. One year after the prior milestones, evaluate

Categories	Activities	Milestones (must be completed in order)
		impact of care coordination strategy including impact on provider organizations KPIs (especially the population of focus). 5. At least one year after the prior milestone, show improvement in at least 2 of the above KPIs in the population of focus.
Evidence-Based Models of Care	**New/Expanded Care Delivery Model:** Choose and implement an evidenced-based model 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.)	1. Develop evidenced-based model, from a list of options provided by DHCS, that is co- designed by feedback from patients, providers, and care teams evidenced by policies/procedures (or equivalent) and key findings from co-design. 2. Develop business case and/or sustainability model for new care delivery model; understand impact on the provider organization's revenue and cost. 3. Define and report baseline data on key measures. Should include and not be limited to Bold Goals and MCAS measures. 4. Implement care delivery model. 5. Scale model to deliver service to 70% of patients within the population of focus; delivery of services means a documented and discrete reportable service delivered to the patient (whether billable or not). 6. At least one year after the prior milestone, show improvement in at least two bold goals and/or MCAS measures.
Value-Based Care and 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	1. 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). 2. Formally identify gaps and action plan

Categories	Activities	Milestones (must be completed in order)
	applied for and been accepted CAN still choose this activity).	with technical assistance from experts (internal or external) in collaboration with MCP(s). 3. Completion of action plan with re-assessment of APM readiness demonstrating no critical gaps in collaboration with MCP(s). 4. Application submitted for FQHC APM (if not already completed). 5. 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).	1. Conduct assessment of value-based payment readiness (PhmCAT and additional financial, data, operational, clinical domains) 2. Formally identify gaps and action plan with technical assistance from experts (internal or external) and discuss results with MCP(s). 3. 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). 4. Address identified gaps in value-based payment readiness assessment, develop necessary infrastructure to succeed in value based contracting arrangement with Medi-Cal MCP(s); create plan to address gaps. 5. Pass MCP readiness review and/or pre-delegation audit for value- based contract. 6. Initiate value-based contract for 12-month period or longer. 7. Evaluate performance in value-based contract with MCP and assess future contract terms.

Categories	Activities	Milestones (must be completed in order)
Leadership and Culture	**DEIB Strategy:** Create and implement an organizational-wide strategy to work on diversity, equity, inclusion, and belonging (DEIB).	1. Develop a DEIB framework, approach, and goals for the provider organization, with support from experts (including those at other similar organizations) and input from provider organization staff, patients and community. 2. Develop and document a formal DEIB plan (including how it relates to any existing overall strategic plan for the organization) and define quantitative/qualitative measures of success and achieving goals. This plan should address health equity for patients of the provider organization. 3. Implement formal DEIB plan and monitor adoption, barriers and adjustments to be made. 4. At least one year after prior milestone, evaluate DEIB plan on, incorporating feedback from stakeholders including the provider organization staff, patients and community members as well as reporting on results of quantitative and qualitative measures, including qualitative measures related to improving health equity for patients of the provider organization. 5. At least one year after prior milestone, show improvement in at least two measures of health equity for patients of the provider organization.
	Strategic Planning: Create and implement a formal process to address the provider organization's strategic planning (which must, at minimum, address DEI and patient and community partnership/engagement, patient	1. 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, objectives, and metrics (must cover at minimum DEI/health equity,

Categories	Activities	Milestones (must be completed in order)
	access, quality metrics, health equity, workforce satisfaction and retention, and value-based care).	patient and community partnership/engagement, patient access, quality, workforce satisfaction and retention, and value-based care), activities that the provider organization will undertake to reach goals and objectives over the period of the strategic plan 2. Incorporate and document clear process for obtaining stakeholder feedback on strategic plan – including frontline staff, management, patients, and community members. 3. Write and publish strategic plan, including communication of plan with all stakeholders. 4. At least one year after prior milestones, show improvement in at least 2 metrics and assess progress toward goals and objectives through written report to stakeholders.

Categories	Activities	Milestones (must be completed in order)
	Patient and Community Partnership/Engagement: Choose and implement a strategy to ensure patient and community input on the provider organization's governance and decision making (e.g., a patient advisory committee, seeking to increase patient representation on the organization's board, etc.).	1. Develop and document a strategy for patient and community engagement that is informed by patients and community members, evidence-based and best practices, and priorities set by the patients served by the provider organization. Obtain direct feedback on the strategy from patient and community members as well as the provider organization's staff. 2. Define and document specific actions to be taken to enhance patient and community engagement, including SMARTIE goals and activities that will be implemented to achieve goals. Patients and community members should be compensated for their time. 3. Implement patient and community engagement activities. 4. At least one year after prior milestone, show improvement on at least 2 metrics related to goals and objectives, including feedback from patients, community members, and the provider organization staff.

Categories	Activities	Milestones (must be completed in order)
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 provider organization may decide to implement integrated behavioral to strengthen its MAT program.* 1. Define behavioral health (BH) screening (which might include traditional BH screening like PHQ-2/9 or AUDIT-C, and/or other related screenings like ACE and intimate partner violence screening) approach for the provider organization, including: specific tools/questions to be used for 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, specialty mental health, crisis intervention services, etc.). 2. Define baseline key operational and quality metrics to monitor progress and determine effectiveness of BH screening; develop a reporting system for these metrics. 3. Develop and document required operational workflows and EHR/HIT system modifications to support behavioral health screening. 4. Implement behavioral health screening strategy. 5. Select evidence-based model for

Categories	Activities	Milestones (must be completed in order)
		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: a. How integrated BH is linked to screening in milestone #1. b. Team-based care with staff to support primary care physicians (PCPs) and co- manage treatment. c. Shared information systems (e.g. EHR or other platform) that facilitate coordination and communication across providers. d. Standardized use of evidence-based clinical guidelines. e. Systematic review and measurement of patient outcomes using registries and patient tracking tools. f. Engagement with broader community services. g. Individualized, person-centered care that incorporates family members and caregivers into the treatment plan. 6. Create a baseline report on operational and quality metrics to monitor progress and impact of BHI model. 7. Implement evidence-based model for behavioral health integration. 8. At least one year after implementation, show improvement on at least two quality metrics related to BH screening and formally evaluate the impact of BHI model on key operational and quality metrics.

Categories	Activities	Milestones (must be completed in order)
Social Health	**Social Needs/Risk Screening and Intervention:** Create and implement a formal process for screening for and intervening on patients' social needs/risks	1. Develop a health-related social needs screening and intervention strategy 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. If the provider organization already does social needs screening and intervention, then adopt a plan to meet criteria above. 2. Set specific goals, objectives, and timeframes for each element of the 5 As (adjustment, assistance, alignment, advocacy, and awareness) outlined as in the National Academy of Sciences framework. 3. Exchange social health data with local CIE/HIO and Managed care plans. 4. At least one year after implementation, complete written evaluation of implementation of social needs screening and intervention strategy, including number of patients screened and linked to services annually, progress toward the provider organization's specific goals and objectives, and key barriers and learnings during the implementation process.