Final Equity and Practice Transformation (EPT) Directed Payment Program Milestones

Introduction

In the Equity and Practice Transformation (EPT) Directed Payment program, 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.

The Population Health Learning Center will provide practices with templates for all deliverables. At the time of this publication, the deliverable templates are under development and subject to change until finalized.

Practices may submit deliverables biannually – by May 1st and by November 1st of each year through 2026.

Category	Milestone	Deliverable
Population Health Management Capabilities Assessment (PhmCAT)	1. Complete year 1 2024 PhmCAT	Assessment
	2. Complete year 2 2025 PhmCAT	Assessment
	3. Complete year 3 2026 PhmCAT	Assessment
Empanelment & 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 method of assigning patients to care team panels, changing assignments, maintaining panel size and continuity, and monitoring empanelment effectiveness.	Policy and procedure

Category	Milestone	Deliverable
Data to Enable Population Health Management	1. Data governance and KPI gap 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
	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 2 external partners, at least 1 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 3 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 2 external partners, at least 1 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 1 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	Clinical guideline(s) and report on guideline adherence

Category	Milestone	Deliverable
Care Delivery Model, cont.	guidelines for patients seen and not seen in clinic, integration of guidelines into the EHR, and tracking provider/care team adherence to guidelines.	
	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
	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)	Workflow and metric reporting

Category	Milestone	Deliverable
Care Delivery Model, cont.	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. 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	
	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 selected population of focus stratified by race and ethnicity and at least one additional characteristic: primary spoken language, sexual orientation, gender identify, housing status, or disability.	KPI report

Category	Milestone	Deliverable
Key Performance Indicator (KPI), cont.	2. Population of Focus HEDIS-like achievement #1: Demonstrate improvement or meet target in 1 population of focus HEDIS-like measure; achievement must be sustained over two consecutive submissions.	KPI report
	3. Population of Focus HEDIS-like achievement #2: Demonstrate improvement or meet target in a 2nd population of focus HEDIS-like measure; achievement must be sustained over two consecutive submissions.	KPI report
	4. Population of Focus HEDIS-like achievement #3: Demonstrate improvement or meet target in 3rd population of focus HEDIS-like measure; achievement must be sustained over two consecutive submissions.	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.	KPI report
	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.	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.	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.	KPI report
	9. Disparity reduction: Demonstrate improvement in at least 1 disparity identified in the reported HEDIS-like measures; improvement must be sustained over two consecutive submissions.	KPI report

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	Child/Youth	Yes
Child and Adolescent Well-Care Visits (WCV)	HEDIS-Like	Child/Youth	Yes
Colorectal Cancer Screening (COL)	HEDIS-Like	Adult Preventive	Yes
Breast Cancer Screening (BCS)	HEDIS-Like	Adult Preventive	Yes
Cervical Cancer Screening (CCS)	HEDIS-Like	Adult Preventive	Yes
Controlling High Blood Pressure (CBP)	HEDIS-Like	Adult Chronic Care	Yes
Glycemic Status Assessment for Patients with DM >9% (GSD)	HEDIS-Like	Adult Chronic Care	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 Indicator (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.*