List of Milestones and Corresponding Dates for the Equity and Practice Transformation (EPT) Directed Payment Program

Introduction

The Equity and Practice Transformation (EPT) Directed Payment Program uses milestones to monitor practice progress and capacity building. Specifically, practices submit deliverables to demonstrate evidence of milestone achievement. Completed deliverables are also the catalyst for directed payments. The Population Health Learning Center provides practices with templates for all deliverables on our Milestones and Deliverables webpage as well as on our PopHealth+ Virtual Learning Platform.

Practices may submit deliverables biannually – by May 1st and by November 1st of each year through 2026. This document lays out when and how each milestone and its accompanying deliverable(s) can be submitted as proof of milestone completion. In addition to this timeline view, the list of milestones organized by category is also available for download. Unless stated otherwise, the dates below represent the first opportunity that a given deliverable can be submitted. Please send any questions to the Learning Center's Programs Team at info@pophealthlc.org.

Summary

Cycle 0	Due May 1, 2024
Cycle 1	Due Nov 1, 2024
Cycle 2	Due May 1, 2025
Cycle 3	Due Nov 1, 2025
Cycle 4	Due May 1, 2026
Cycle 5	Due Nov 1, 2026

Overview

Milestone #	Submission cadence	What's due	Dependency	Which cycle	Who needs to submit for payment?
1	Every Year	Population Health Management Capabilities Assessment Tool (PhmCAT)		0	Practices
2	One Time	Empanelment Assessment		1	Practices
3	One Time	Empanelment Policy and Procedures (P&P)		1	Practices
4	One Time	Data Governance P&P		1	Practices
4	One Time	Data Gap Assessment		1	Practices
5	Every Year	PhmCAT	1	2	Practices
6	One Time	Data Implementation Plan	4	2	Practices
7	One Time	Stratified HEDIS data on all measures		2	Practices
8	One Time	Disparity Reduction Plan	7	3	Practices
9	One Time	Care Team Assessment		3	Practices
10	One Time	Clinical Guidelines		3	Practices
11	One Time	Outreach & Engagement		3	Practices
12	One Time	Pre-Visit Planning		3	Practices
13	One Time	Data Progress Report	6	3	Practices
14	One Time	PhmCAT	5	4	Practices
15	One Time	BH Screen & Link		4	Practices
16	One Time	SH Screen & Link		4	Practices
17	One Time	VBP Assessment		4	Practices
18	Every cycle	KPI Assessment: Empanelment		1, 2, 3, 4, 5	Practices
19	Every cycle	KPI Assessment: Continuity		1, 2, 3, 4, 5	Practices
20	Every cycle	KPI Assessment: TNAA		1, 2, 3, 4, 5	Practices
21	Every cycle	KPI Assessment: Disparity Reduction (1 disparity in 1 PoF measure)		3, 4, 5	Practices

22	Every cycle	KPI Assessment: Assigned & Seen		2, 3, 4, 5	MCPs
23	Every cycle	KPI Assessment: HEDIS Metrics*		2, 3, 4, 5	MCPs
24	Every cycle	KPI Assessment: HEDIS Metrics*		2, 3, 4, 5	MCPs
25	Every cycle	KPI Assessment: HEDIS Metrics*		2, 3, 4, 5	MCPs

**For the KPI Assessments: HEDIS Metrics (Milestones 23, 24, and 25), practice data is required as supplemental submissions to the data that MCPs are submitting to the Learning Center. Practices should submit data for all HEDIS-like Population of Focus (PoF) measures during each of the required cycles. See the table "EPT Key Performance Indicators (KPIs)" on page 12 for the list of HEDIS-like measures.*

Year 1 (2024): 4 Milestones

May 1, 2024 (Cycle 0)

	Category	Milestone	Deliverable
1.	Population Health Management Capabilities Assessment (PhmCAT)	**Complete year 1 2024 PhmCAT**	Assessment

November 1, 2024 (Cycle 1)

	Category	Milestone	Deliverable
2.	**Empanelment & Access**	**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

	Category	Milestone	Deliverable
3.	**Empanelment & Access**	**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 (P&P)
4.	**Data to Enable Population Health Management**	**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 (P&P) and assessment

Y2 (2025): 9 Milestones

May 1, 2025 (Cycle 2)

	Category	Milestone	Deliverable
5.	**Population Health Management Capabilities Assessment (PhmCAT)**	**Complete year 2 2025 PhmCAT**	Assessment
6.	**Data to Enable Population Health Management**	**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) *Note: Before completing this Milestone, the team needs to have submitted Milestone 4: Data governance and HEDIS reporting assessment*	Implementation Plan
7.	**Stratified HEDIS-like measures**	**Stratify HEDIS-like measures:** Submit 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 identity, housing status, payer, or disability.	Stratified HEDIS-like Measures Report
18, 19, 20	**Key Performance Indicators (KPI)**	**Submit KPI Updates** • Empanelment • Continuity	KPI Assessment

	Category	Milestone	Deliverable
		• Third Next Available Appointment *Note: achievement/improvement must be sustained over two consecutive submissions or met in the final submission.*	

November 1, 2025 (Cycle 3)

	Category	Milestone	Deliverable
8.	**Care Delivery Model**	**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. *Note: Before completing this Milestone, the team needs to have submitted Milestone 7: Stratify HEDIS-like measures*	Implementation Plan
9.	**Care Delivery Model**	**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
10.	**Care Delivery Model**	**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	Clinical guideline(s) and Report on Guideline Adherence

	Category	Milestone	Deliverable
		patients seen and not seen in clinic, integration of guidelines into the EHR, and tracking provider/care team adherence to guidelines.	
11.	**Care Delivery Model**	**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
12.	**Care Delivery Model**	**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
13.	**Data to Enable Population Health Management**	**Progress report on implementing data improvement strategies:** Demonstrate evidence of implementing at least 3 strategies from the data implementation plan including: • Identifying and outreaching to the assigned but unseen population • Using gaps in care reports that include practice and MCP data • Data exchange with 2 external partners, at least 1 of which is a Qualified Health Information Organization (QHIO)	Progress Report

	Category	Milestone	Deliverable
		Note: Before completing this Milestone, the team needs to have submitted Milestone 6: Data Implementation Plan	
18, 19, 20, 21	**Key Performance Indicators (KPI)**	**Submit KPI updates** • Empanelment • Continuity • Third Next Available Appointment • Disparity Reduction *Note: achievement/improvement must be sustained over two consecutive submissions or met in the final submission.*	KPI Assessment

Y3 (2026): 12 Milestones

May 1, 2026 (Cycle 4)

	Category	Milestone	Deliverable
14.	**Population Health Management Capabilities Assessment (PhmCAT)**	**Complete year 3 2026 PhmCAT**	Assessment
15.	**Care Delivery Model**	**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	Workflow and Metric Reporting

		closed loop referrals. Demonstrate how processes are working through a report of the following: 1. Depression screening a. Percent of population of focus screened with PHQ-2/PHQ-9 (80% target) b. Percent of patients with positive screening who are linked to services (80% target) c. Percent of patients linked to services with a close looped referral 2. SUD screening a. Percent of population of focus screened for SUD (80% target) b. Percent of positive SUD screens linked to services (80% target) c. Percent of patients linked to services with a close looped referral	
16.	**Care Delivery Model**	**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)	Workflow and Metric Reporting

		iii. Percent of patients linked to services with a closed looped referral.	
17.	**Value Based Payment (VBP)**	**VBP assessment:** Conduct assessment of value-based payment readiness, identify gaps, and develop an action plan in coordination with the MCP.	Assessment
18,19, 20, 21	**Key Performance Indicators (KPI)**	**Submit KPI Updates** • Empanelment • Continuity • Third Next Available Appointment • Disparity Reduction *Note: achievement/improvement must be sustained over two consecutive submissions or met in the final submission.*	KPI Assessment

November 1, 2026 (Cycle 5)

Note: This will be the last opportunity to submit deliverables to complete any outstanding EPT Milestones

	Category	Milestone	Deliverable
18.	**Key Performance Indicators (KPI)**	**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 Assessment
19.	**Key Performance Indicators (KPI)**	**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 Assessment

	Category	Milestone	Deliverable
20.	**Key Performance Indicators (KPI)**	**Third next available appointment (TNAA) 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 Assessment
21.	**Key Performance Indicators (KPI)**	**Disparity reduction:** Demonstrate improvement in at least 1 disparity identified in the reported HEDIS-like measures; improvement must be sustained over two consecutive submissions or met in the final submission.	KPI Assessment
22.	**MCP Key Performance Indicators (KPI)**	**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.	MCP KPI Assessment
23.	**MCP Key Performance Indicators (KPI)**	**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 or met in the final submission.	MCP KPI Assessment
24.	**MCP Key Performance Indicators (KPI)**	**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 or met in the final submission.	MCP KPI Assessment
25.	**MCP Key Performance Indicators (KPI)**	**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 or met in the final submission.	MCP KPI Assessment

EPT Key Performance Indicators (KPIs)

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 (TNAA)	Administrative	All	No
Assigned Patients Seen in a 12-Month Period	Administrative	All	No

** For measures that require stratification, MCPs and Practices should stratify measures by race and ethnicity as well as one additional characteristic.*

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.*