



Equity and Practice Transformation (EPT) Payment Program
Value Based Payment (VBP) Milestone

Example Value Based Payment (VBP) Milestone from Provident Primary Care

Milestone Description

Conduct an assessment of value-based payment (VBP) readiness, identify gaps, and develop an action plan to improve readiness for VBP. The VaPCAT is the first component of the EPT VBP milestone; EPT practices will also submit the VBP deliverables template which includes a gap analysis and action plan. The VBP milestone can be submitted in May or November 2026 via the EPT Deliverable Portal.

The EPT VBP milestone is intended to support EPT practices to increase their readiness to enter into VBP contract(s). This milestone is comprised of the following components:

1. **Value-Based Pay Capability Assessment Tool (VaPCAT):** The VaPCAT supports primary care practices in assessing their capabilities for engaging in VBP arrangements across five core domains: (a) leadership, governance, and legal; (b) operations; (c) data, analytics, and technology; (d) financial; and, (e) payer and partner relations. It was developed through a 30-member Medi-Cal VBP Implementation Workgroup that included multi-stakeholder representatives from state agencies, provider associations, health plans, and practices. The tool was informed by existing value-based payment frameworks, adapted from national literature, and vetted and formally tested with a diverse group of practices. Refinements were made based on feedback.

The VaPCAT complements the population health domains assessed through the PhmCAT. Considering results from both tools provides a more nuanced understanding of the clinical capabilities, population health management skills and organizational infrastructure needed to succeed in VBP arrangements. The VaPCAT is best completed by an individual or team with visibility into financial, operational, and data assets of the organization. This is most often the practice owner(s) or senior or executive organizational leader(s). If no one holds all those insights, it would be helpful to solicit input from several individual leaders. A hard copy of the VaPCAT is accessible [here](#).

2. **Gap analysis to identify areas of improvement:** EPT practices will use the results of the VaPCAT to identify three areas of opportunity to increase readiness to participate in VBP arrangements.



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3. **Develop an action plan to improve readiness for VBP:** For each identified improvement area, EPT practices will develop a plan to improve readiness for VBP. This plan will include identifying: desired goal or objective; activities and timeline to achieve this objective; key decisions; structural changes; staffing and leadership engagement; how progress will be measured; and, any anticipated risks and mitigation strategies. EPT practices will also describe the process they undertook to develop the action plan.

Entering into a new VBP contract **is not** required to meet this milestone.

A. Value-Based Payment Capability Assessment Tool (VaPCAT)

Provident Primary Care (PPCI) completed the VaPCAT in April 2026 and used the results to complete the gap analysis and action plan that follow. The completed VaPCAT is not included in this exemplar.

B. Gap Analysis to Identify Areas of Improvement

VBP Gap Analysis					
Domains	Current State (brief description of existing capabilities)	VBP Domain Maturity (scale of 0 – 5)	Specific Capability Gaps	Priority for Action (high, medium, low)	Rationale
Leadership, Governance, and Legal (e.g., organizational alignment & VBP implementation, governance & oversight, and risk assessment)	PPCI's Owner/Medical Director and Practice Manager actively champion VBP work. Senior leadership supports VBP implementation and infrastructure investment. PPCI does not have a formal VBP-	3	• Committee or governance body specific to overseeing the VBP arrangement* • Determination of whether an organizational entity can bear risk or whether it should join or create a risk-bearing entity*	Medium	Leadership champions and board-level support are already in place, which are the most critical foundational elements. Formalizing governance structures is important to optimize performance over time but does not block near-



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	specific committee or governance body, and a formal determination of whether PPCI should bear risk independently or through a partner has not yet been documented. The practice currently relies on its ACO partner (Aledade) and MCP (CCAH) for risk-bearing structure.				term VBP participation, which is conducted through Aledade and CCAH.
Operations (e.g., educate staff on VBP, dedicated staff responsible for and skilled in negotiating VBP contracts, care management approach, contracting/credentialing/grievance/utilization review functions)	PPCI is starting to formalize internal responsibility for VBP staff education and contract negotiation; these functions are emerging but not yet assigned to a dedicated owner. Care management for complex patients is delivered through PPCI's PCPs in coordination with Aledade care	2	• Person responsible for educating organization staff about VBP and its impact on patient care • Person responsible for and skilled in negotiating VBP contracts/terms with payers • Person responsible for identifying vendors or partners to support the VBP work and	High	Designating internal staff for VBP education and contract review is foundational, low-cost, and directly enables PPCI to engage more meaningfully with Aledade and CCAH on contract terms and quality performance. Without named ownership, accountability and follow-through on VBP



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Domains	Current State (brief description of existing capabilities)	VBP Domain Maturity (scale of 0 – 5)	Specific Capability Gaps	Priority for Action (high, medium, low)	Rationale
	management resources and CCAH-funded care coordination. Credentialing, appeals/grievances, and utilization management functions are accessed through Aledade and CCAH; PPCI does not perform these on behalf of a payer.		assessing terms and benefits and potential risks and downsides Care management approach for identifying and managing the care of individuals with complex care needs, including those with co-occurring medical, mental health and/or substance use disorder		improvement work are at risk.
Data, Analytics, and Technology (e.g., performance measurement, track quality & cost, data-driven decision making, QHIO connection, tracking rising risk)	PPCI reviews and reconciles attribution rosters from Aledade and CCAH against active patients. Quality performance dashboards are in place through Aledade's population health platform and the CCAH provider portal. Tracking of rising-risk patients and targeted interventions is an area of strength, supported	4	Ability to obtain and analyze claims data*	High	Strengthening internal reporting reduces dependence on partner timelines, improves real-time decision-making, and is a direct extension of in-progress work with the IMS EHR developer and CCAH portal monitoring already underway for the Disparity Reduction KPI deliverable. The recently established Manifest MedEx QHIO



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	by Aledade's analytics. PPCI established a QHIO connection through a signed agreement with Manifest MedEx on February 20, 2026; staff orientation training was completed in April 2026 and all relevant staff have user access to the Manifest MedEx portal for hospital admission/discharge information and broader patient health data. Claims data and hospital/specialty/pharmacy utilization tracking are accessed through ACO/MCP partners. PPCI is actively building internal reporting within IMS, our EHR system, to capture depression screening and follow-up at the visit-note level				connection provides PPCI with an external real-time data source (e.g., hospital ADT events) that will be most valuable when integrated with internal IMS reporting and care-team workflows — making internal reporting capacity the highest-leverage data investment available to PPCI in 2026.



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	and through CPT billing entries.				
Financial (e.g., model risk & potential payments, possess sufficient billing and coding expertise, dashboards, reserves)	PPCI has billing and coding expertise in place, with room for improvement on capturing all care delivered in HCC/risk-adjustment terms. Methodology for allocating gains/losses among PCPs is in place at a basic level. Ability to model VBP revenue opportunity against infrastructure cost is starting to be in place — preliminary modeling occurs through Aledade-provided pro-formas, but PPCI does not yet conduct independent financial modeling. Spend-tracking dashboards are accessed through	2	• Ability to assess potential revenue associated with the VBP opportunity, taking into account infrastructure costs and incentive payments • Billing and coding expertise to capture all care delivered • Funding of capital reserves*	High	Without internal financial modeling capability, PPCI cannot independently evaluate whether to expand existing VBP arrangements with Aledade and CCAH or explore additional contracts. Improved HCC/risk-adjustment coding directly affects revenue under existing shared-savings arrangements. This is foundational to long-term VBP sustainability.



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Domains	Current State (brief description of existing capabilities)	VBP Domain Maturity (scale of 0 – 5)	Specific Capability Gaps	Priority for Action (high, medium, low)	Rationale
	Aledade. Capital reserves to fund VBP infrastructure investment are at an early stage. Pay-claims-on-fee-schedule capability is not present and is not relevant for a practice of PPCI's size.				
Payer and Partner Relations (e.g., productive relationships with clinical and community partners; functional data exchange; shared accountability for quality/cost)	PPCI maintains productive working relationships with hospitals, specialists, behavioral health providers, and community organizations in our service area to support care coordination and transitions. Functional data sharing with key partners is in place but with room for improvement, including ADT feeds and closed-loop referral capabilities. PPCI has	3	• Functional data sharing capabilities with key partners like hospitals, specialists, behavioral health providers, community organizations, etc. within the service area (e.g., ADT feeds, closed-loop referrals)	Medium	Foundational partnerships with Aledade and CCAH are functional and productive. Improvements in ADT/closed-loop referral and behavioral-health data exchange are important to optimize population-health performance, but they do not block participation in current VBP arrangements. Many of these improvements depend



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VBP Gap Analysis					
Domains	Current State (brief description of existing capabilities)	VBP Domain Maturity (scale of 0 – 5)	Specific Capability Gaps	Priority for Action (high, medium, low)	Rationale
	an active and productive relationship with Aledade (ACO) and CCAH (MCP), including shared accountability for quality, cost, and patient attribution. Data exchange with these partners is in place, with continued opportunities to expand bidirectional flow.				on external partner timelines.

Based on the gap analysis above, list three capabilities your EPT practice will address to improve your readiness for VBP contracting, including: (1) the specific capability you want to develop or improve; (2) why this is a priority for your practice; and, (3) if the capability is best developed/improved internally or provided by a partner (e.g., IPA, MCP, ACO). (Note: These three areas of improvement will become the basis of your VBP action plan.)

- Capability 1: **Designated VBP Operations Lead and Internal VBP Education (Operations domain)**
Specific capability: Formally designate a staff member responsible for VBP education across the practice and for reviewing/negotiating VBP contract terms with Aledade, CCAH, and any future payer partners.



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Why this is a priority: Without named ownership, VBP follow-through is at risk. PPCI's leadership champions VBP, but day-to-day execution requires a designated lead. This is a low-cost, high-leverage step that directly enables more meaningful engagement with existing ACO and MCP partners.

Developed internally or through a partner: Both internally and through a partner

- Capability 2: **Internal Practice-Level Performance Reporting within IMS EHR (Data, Analytics & Technology domain)**

Specific capability: Build internal reporting capabilities within IMS, our EHR system, that capture screening completion, quality measures, and follow-up status through multiple data points (visit-note entries, CPT billing codes, structured documentation fields), and integrate non-compliance monitoring through the CCAH provider portal.

Why this is a priority: PPCI currently relies on Aledade and CCAH platforms for performance dashboards, which creates dependency on partner reporting cycles. With the recently established Manifest MedEx QHIO connection providing a new external real-time data source, internal reporting in IMS becomes the critical integration layer — giving PPCI leadership real-time visibility into quality and disparity-reduction performance, supporting both VBP contract performance and the practice's active disparity-reduction work.

Developed internally or through a partner: Internally

- Capability 3: **VBP Financial Modeling and Risk-Adjustment Coding Capture (Financial domain)**

Specific capability: Develop the internal capacity to model VBP revenue opportunity against infrastructure cost, allocate gain/loss methodology among participating PCPs, and improve risk-adjustment (HCC) coding capture across the patient panel.

Why this is a priority: Independent financial modeling is essential for PPCI to evaluate whether to expand current VBP arrangements or pursue new ones, and HCC coding capture directly affects revenue under existing shared-savings arrangements with Aledade. This domain currently sits at the lowest maturity rating and is foundational to long-term VBP sustainability.

Developed internally or through a partner: Both internally and through a partner



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C. Develop an Action Plan to Improve Readiness for VBP

The action plan describes what will be involved in improving the three capabilities practices identified in the gap analysis. This section also describes the planning activities practices engaged in to develop the plan.

1. Summarize the process your practice used to develop the action plan, including:

a. A brief overview of your activities and approach

Activities and approach: PPCI developed this action plan through a structured review process led by the Practice Manager and Owner/Medical Director. The team (1) reviewed the completed VaPCAT results submitted in April 2026; (2) mapped each VaPCAT response to the five gap-analysis domains and assigned a 0–5 maturity rating using the template scale; (3) identified the most significant gaps in each domain and assigned priority ratings of high, medium, or low; (4) selected three foundational capabilities for action that are achievable within the EPT program timeline (through December 2026); and (5) drafted an action plan for each capability with major activities, timelines, decisions, structural changes, staffing assignments, and progress measures.

b. The leadership and staff involved in the discussions

Leadership and staff involved in the discussions: Owner/Medical Director (executive and clinical leadership champion); Practice Manager (operational lead and EPT deliverable owner); Lead Medical Assistant (workflow input); and PPCI's billing team (financial and coding input). Discussions also drew on guidance from PPCI's Aledade ACO partner and from the EPT 2026 Value-Based Payment Learning Community materials.

c. How this aligns with other priorities in your practice

Alignment with other practice priorities: This action plan aligns directly with several priorities already underway at PPCI. The Capability 2 reporting build-out within IMS is a continuation of the EHR development work named in PPCI's May 2026 Disparity Reduction KPI submission, where the practice committed to internal



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reporting on depression screening and follow-up. The Capability 1 staff-designation work supports PPCI's broader EPT participation across all EPT deliverables. The Capability 3 financial-modeling work supports continued participation in PPCI's existing Aledade ACO contract and the practice's long-term sustainability goals. No misalignment with existing priorities was identified.

Using the action plan table below, provide more information on the following components of your plan for each of the three capabilities:

- **Goals:** Briefly describe the capability you want to build or refine and how this will improve your success with participating in a VBP model.
- **Major Activities:** List a minimum of 3 steps your practice will engage in to build, refine or contract for this capability. For each activity, indicate the month/year you expect to complete the activity.
- **Key Decisions:** Describe at least two key decisions you expect your practice will need to make to make progress on your improvement opportunity (e.g., building internally vs. working with a partner; allocating reserve funds; defining performance benchmarks).
- **Structural Changes:** Describe at least one structural change you expect you'll need to make (e.g., governance, staffing, contracting, workflow redesign).
- **Staffing:** Which staff will be responsible for managing this process? What other key staff will be involved?
- **Leadership Engagement:** How will you engage leadership? What do you need from leadership to be successful?
- **Measuring Progress:** For each improvement opportunity, provide at least 1 specific and measurable indicator of progress you will use.



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VBP Action Plan							
Area of Improvement	Goals	Major Activities & Timeline	Key Decisions	Structural Changes	Staffing	Leadership Engagement	Measuring Progress
Capability 1: Designated VBP Operations Lead and Internal VBP Education (Operations domain)	Designate a Practice Manager-led VBP function with clear accountability for staff education and contract review, enabling more effective engagement with Aledade and CCAH and any future VBP partners.	- Formally name Practice Manager as VBP Lead and document role expectations — Jul 2026 - Develop and deliver an internal VBP 101 staff-education session for clinical and front-office staff — Sep 2026 - Establish quarterly VBP contract review cadence with Aledade and CCAH, including review of quality benchmarks and attribution rosters — Oct 2026 - Develop a VBP staff onboarding checklist for new hires — Nov 2026	- Whether to add VBP responsibilities to the Practice Manager role description or create a separate part-time VBP coordinator role over time - Which staff training format (live in-service vs. asynchronous self-paced) will be most effective for PPCI's small team	Update Practice Manager job description to formally include VBP coordination and contract-review responsibilities. Add a recurring VBP standing item to monthly leadership meetings.	Lead: Practice Manager. Other staff involved: Owner/Medical Director (oversight), Lead MA (workflow input), billing team (contract terms input).	Owner/Medical Director will champion the VBP role internally, approve the updated job description, and reinforce VBP priorities at staff meetings. Leadership support is needed to protect Practice Manager time for VBP activities.	VBP Lead role formally documented; ≥1 internal VBP education session delivered to all staff by Q4 2026; ≥2 documented quarterly contract reviews with Aledade/CCAH completed.
Capability 2: Internal Practice-Level Performance Reporting within IMS EHR (Data, Analytics)	Build internal practice-level reporting in IMS (EHR system) that captures screening,	Finalize reporting requirements specification with IMS IT development	Build reporting fully internally with IMS IT vs. supplement with an external	Establish a recurring data-review huddle (weekly or biweekly) with Practice Manager, Lead MA,	Lead: Practice Manager (project owner). Other staff involved: IMS IT development team	Owner/Medical Director will review pilot reports and approve clinical content. Leadership	First internal IMS report functional and in use by Sep 2026; weekly CCAH non-compliance



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& Technology domain)	quality, and follow-up data at the visit level, integrated with CCAH portal monitoring for non-compliance — reducing dependency on partner reporting cycles.	team (data points, refresh cadence, output format) — Jul 2026 • Pilot first internal report on depression screening and follow-up (visit-note + CPT capture) — Sep 2026 • Operationalize CCAH portal-based non-compliance monitoring workflow with weekly outreach review — Oct 2026 • Expand internal reporting to additional quality measures (e.g., diabetes, hypertension control) — Nov 2026	analytics vendor or Aledade-provided tooling • Which staff member will own daily/weekly review of CCAH non-compliance lists and outreach assignments	and Owner/Medical Director to review reports and assign outreach. Modify front-office workflow to incorporate pre-visit non-compliance flags from CCAH portal.	(build), Owner/Medical Director (clinical content review), Lead MA (workflow integration), Care Coordinator (outreach execution).	commitment is needed to fund IMS development time and to support workflow changes for non-compliance follow-up.	review documented; ≥1 additional quality measure added to internal reporting by end of 2026.
Capability 3: VBP Financial Modeling and Risk-Adjustment Coding Capture (Financial domain)	Develop internal capacity to model VBP revenue and infrastructure cost, refine gain/loss methodology among PCPs, and improve HCC/risk-adjustment coding	• Conduct an HCC coding capture review with the billing team to identify under-captured chronic conditions — Aug 2026	• Whether to engage an external HCC coding consultant for the initial capture review or rely on internal billing team capacity	Add a recurring quarterly financial review meeting between Owner/Medical Director, Practice Manager, and billing team to review HCC capture rates and	Lead: Practice Manager + billing team. Other staff involved: Owner/Medical Director (clinical documentation oversight and final allocation policy	Owner/Medical Director will lead PCP engagement on HCC documentation and approve the gain/loss allocation methodology. Leadership	HCC capture rate baseline established by Aug 2026 and tracked quarterly; internal VBP modeling worksheet completed by Oct 2026; written



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	capture across the panel.	• Implement provider-facing HCC documentation reminders and pre-visit chart prep for chronic-condition recapture — Sep 2026 • Build an internal VBP revenue/cost modeling worksheet using Aledade pro-forma data and PPCI infrastructure cost estimates — Oct 2026 • Document a formal gain/loss allocation methodology among PCPs — Nov 2026	• How to allocate any future shared-savings dollars among PCPs (equal split vs. attribution-weighted vs. quality-performance-weighted)	Aledade pro-forma performance. Establish a written gain/loss allocation policy.	decisions), PCPs (chart documentation), Aledade representative (pro-forma input).	commitment is needed for PCP buy-in on documentation changes and for capital decisions on infrastructure investment.	gain/loss allocation policy adopted by Nov 2026.
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1. Identify the two most likely implementation risks and describe why you think you are likely to encounter them.

Risk 1: Practice Manager bandwidth competing with day-to-day operations

Why it is likely: PPCI is a small private practice and the Practice Manager already carries responsibility for clinical operations, EPT deliverables, staff supervision, and patient escalations. Adding VBP lead duties — including contract



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review, internal education, and reporting build-out — creates real capacity risk. Without explicit time protection, VBP work can be deprioritized during busy clinical periods.

Risk 2: Dependency on external partner timelines (IMS EHR development team, Aledade, CCAH)

Why it is likely: Two of the three priority capabilities (internal IMS reporting and VBP financial modeling using Aledade pro-formas) depend on external partners delivering scoped work or data on schedule. EHR vendor development queues and ACO/MCP reporting cycles are outside PPCI's direct control, and delays from any of these partners could push milestone dates.

2. For each risk, provide at least one mitigation strategy.

Risk 1 mitigation: (1) Owner/Medical Director will formally protect a recurring weekly time block (e.g., 2–4 hours) on the Practice Manager calendar dedicated to VBP work; (2) the action plan timeline above sequences activities across Q3 and Q4 2026 rather than concentrating them, so workload remains manageable; (3) Lead MA and billing team will own discrete subtasks (workflow integration, HCC capture review) so the Practice Manager is coordinating rather than executing every component.

Risk 2 mitigation: (1) PPCI will engage IMS EHR development team, Aledade, and CCAH early — within 30 days of plan finalization — to confirm scope, deliverables, and target dates in writing; (2) the action plan will be sequenced so that internally-controlled activities (e.g., HCC documentation review with the billing team, Practice Manager role designation, internal staff education) are not blocked by partner-dependent milestones; (3) PPCI will track partner deliverables in a simple status log and escalate slippage to leadership at the monthly leadership meeting; (4) where partner delays occur, PPCI will use manual interim workflows (e.g., spreadsheet-based tracking) rather than pausing the work entirely.