



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

Updated **January 2026**

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 and to earn EPT directed payment. 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 well as additional programmatic requirements and recommendations. 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.

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Milestone Requirements for Continued Participation in EPT

EPT practices are required to complete specific milestones by November 2025 and May 2026 to continue participating in the program. This allows practices to achieve EPT directed payment, demonstrate their progress in the core EPT population health content, and meet the DHCS requirement of annual completion of the Population Health Management Capabilities Assessment Tool (PhmCAT).

- **By November 2025**, EPT practices must submit their 2025 PhmCAT and at least one 2024 data or empanelment milestone. Practices may submit, but are not required to submit, additional milestones.
- **By May 2026**, EPT practices must submit their 2026 PhmCAT and the following deliverables:
 - Empanelment Policy and Procedure
 - Data Governance Policy and Procedure
 - Data Implementation Plan
 - Disparity Reduction Plan
 - At least one of the Care Delivery Model Deliverables: Care Team Assessment, Clinical Guidelines, Outreach and Engagement, or Pre Visit Planning milestones.

The May 2026 submission is also EPT practices’ first opportunity to submit the behavioral health, social health, and value-based payment milestones. Because these milestones can also be submitted in November 2026, the Learning Center recommends that practices first focus on the milestones that are required to be submitted in May 2026. Once the required milestones are complete, practices should move onto new milestones.

EPT practices should submit all milestones by the final deliverable cycle, in November 2026. EPT practices will also submit:

- Final KPI submissions for Empanelment, Continuity, TNAA, and Disparity Reduction (these should be submitted every cycle, even if the target is achieved)
- Final HEDIS-like measure data (these should be submitted every cycle)
- Any EPT deliverables not previously submitted

There are four EPT milestones that use MCP produced rates to determine practice performance – the Population of Focus HEDIS®-like milestones (3 milestones) and the assigned and seen milestone. For detail on these milestones, please see the chart below specifying the reporting timeline for these milestones.

Milestone & Deliverable Submission Chart

Unless stated otherwise, the dates below represent the first opportunity that a given deliverable can be submitted.

| Milestone | Milestone Number | Submission cadence | Dependency | Submission Cycle | Who is submitting for payment? | Notes |
|---|------------------|--------------------|------------|------------------|--------------------------------|--------------------------------|
| Population Health Management Capabilities Assessment Tool (PhmCAT) | 1, 5, 14 | Every Year | | Annually in May | Practices | Annual requirement to complete |

| | | | | | | |
|--|----|----------|--------------------------|----------|-----------|---|
| Empanelment Assessment | 2 | One Time | | Nov 2024 | Practices | |
| Empanelment Policy and Procedures (P&P) | 3 | One Time | | Nov 2024 | Practices | Required to be submitted by May 2026 |
| Data Governance P&P | 4 | One Time | | Nov 2024 | Practices | Required to be submitted by May 2026 |
| Data Gap Assessment | 4 | One Time | | Nov 2024 | Practices | |
| Data Implementation Plan | 6 | One Time | Data P&P and Assessment | May 2025 | Practices | Required to be submitted by May 2026 |
| Stratified HEDIS® data on all measures | 7 | One Time | | May 2025 | Practices | |
| Disparity Reduction Plan | 8 | One Time | Stratified HEDIS | Nov 2025 | Practices | Required to be submitted by May 2026 |
| Care Team Assessment | 9 | One Time | | Nov 2025 | Practices | At least one of the models of care milestones is required to be submitted by May 2026 |
| Clinical Guidelines | 10 | One Time | | Nov 2025 | Practices | |
| Outreach & Engagement | 11 | One Time | | Nov 2025 | Practices | |
| Pre-Visit Planning | 12 | One Time | | Nov 2025 | Practices | |
| Data Implementation Plan Progress Report | 13 | One Time | Data Implementation Plan | Nov 2025 | Practices | |
| Behavioral Health Screen & Link | 15 | One Time | | May 2026 | Practices | Can be submitted in the either 2026 deliverables cycle |
| Social Health Screen & Link | 16 | One Time | | May 2026 | Practices | |

| | | | | | | |
|---|----|-------------|--|--|-----------|---|
| Value Based Payment Assessment | 17 | One Time | | May 2026 | Practices | |
| KPI Assessment: Empanelment | 18 | Every cycle | | Every cycle | Practices | |
| KPI Assessment: Continuity | 19 | Every cycle | | Every cycle | Practices | |
| KPI Assessment: TNAA | 20 | Every cycle | | Every cycle | Practices | |
| KPI Assessment: Disparity Reduction (1 disparity in 1 PoF measure) | 21 | Every cycle | | Nov 2025, May 2026, Nov 2026 | Practices | |
| KPI Assessment: Assigned & Seen | 22 | Every cycle | | May 2025, Nov 2025, May 2026, Nov 2026 | MCPs | See MCP produced milestones table for information on these milestones |
| KPI Assessment: HEDIS® Metrics* | 23 | Every cycle | | | | |
| KPI Assessment: HEDIS® Metrics* | 24 | Every cycle | | | | |
| KPI Assessment: HEDIS® Metrics* | 25 | Every cycle | | | | |

**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 2024 Milestones

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

November 2024 Milestones

| | 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 |
| 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 |

Year 2 (2025): 9 Milestones

May 2025 Milestones

| Category | Milestone | Deliverable |
|----------|--|--|
| 5. | Population Health Management Capabilities Assessment (PhmCAT) | Assessment |
| 6. | <p>Data to Enable Population Health Management</p> <p>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:</p> <ul style="list-style-type: none"> 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) <p><i>Note: Before completing this Milestone, the team needs to have submitted Milestone 4: Data governance and HEDIS® reporting assessment</i></p> | Implementation Plan |
| 7. | Stratified HEDIS®-like measures | Stratified HEDIS®-like Measures Report |

| | Category | Milestone | Deliverable |
|------------|---|--|----------------|
| 18, 19, 20 | Key Performance Indicators (KPI) | <p>Submit KPI Updates</p> <ul style="list-style-type: none"> • Empanelment • Continuity • Third Next Available Appointment <p><i>Note: achievement/improvement must be sustained over two consecutive submissions or met in the final submission.</i></p> <p>In addition to the Empanelment and Access KPIs, the KPI Assessment also includes reporting on Medi-Cal Assigned Lives and performance on EPT Population of Focus (PoF) Measures across all Medi-Cal Assigned Lives.</p> | KPI Assessment |

November 2025 Milestones

| | Category | Milestone | Deliverable |
|----|----------------------------|---|------------------------------------|
| 8. | Care Delivery Model | <p>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.</p> <p><i>Note: Before completing this Milestone, the team needs to have submitted Milestone 7: Stratify HEDIS®-like measures</i></p> | Implementation Plan |
| 9. | Care Delivery Model | <p>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.</p> | Assessment and Implementation Plan |

| | Category | Milestone | Deliverable |
|-----|--|---|---|
| 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 patients seen and not seen in clinic, integration of guidelines into the EHR, and tracking provider/care team adherence to guidelines. | Clinical guideline(s) and Report on Guideline Adherence |
| 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: <ul style="list-style-type: none"> • 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 |
|----------------|--|----------------|
| | <i>Note: Before completing this Milestone, the team needs to have submitted Milestone 6: Data Implementation Plan</i> | |
| 18, 19, 20, 21 | Submit KPI updates <ul style="list-style-type: none"> • Empanelment • Continuity • Third Next Available Appointment • Disparity Reduction <i>Note: achievement/improvement must be sustained over two consecutive submissions or met in the final submission.</i> | KPI Assessment |

Year 3 (2026): 12 Milestones

May 2026 Milestones

EPT practices can submit the behavioral health, social health, and value-based payment milestones in May or November 2026. While preparing for the May 2026 submission cycle, the Learning Center recommends that practices first complete the May 2026 required milestones prior to working on new milestones. The milestones that are required to be submitted by May 2026 are the Empanelment Policy and Procedure; Data Governance Policy and Procedure; Data Implementation Plan; Disparity Reduction Plan; and at least one of the following: Care Team Assessment, Clinical Guidelines, Outreach and Engagement, or Pre Visit Planning milestones.

| Category | Milestone | Deliverable |
|----------|-------------------------------------|------------------------------------|
| 14. | Population Health Management | Complete year 3 2026 PhmCAT |
| | | Assessment |

| | Capabilities Assessment (PhmCAT) | | |
|-----|---|--|-------------------------------|
| 15. | Care Delivery Model | <p>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:</p> <ol style="list-style-type: none"> 1. Depression screening <ul style="list-style-type: none"> • Percent of population of focus screened with PHQ-2/PHQ-9 • Percent of patients with positive screening who are linked to services <ol style="list-style-type: none"> a. Percent of patients linked to services with a close looped referral • SUD screening • Percent of population of focus screened for SUD • Percent of positive SUD screens linked to services <ol style="list-style-type: none"> b. Percent of patients linked to services with a close looped referral | Workflow and Metric Reporting |
| 16. | Care Delivery Model | <p>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:</p> | Workflow and Metric Reporting |

| | | | |
|---------------|---|---|----------------|
| | | <ul style="list-style-type: none"> • Percent of population of focus screened for HRSN • Percent of patients with positive HRSN screening who are linked to services • Percent of patients linked to services with a closed looped referral. | |
| 17. | Value Based Payment (VBP) Updated January 2026 | VBP assessment: Conduct assessment of value-based payment readiness, identify gaps, and develop an action plan to improve readiness for VBP contracting. | Assessment |
| 18,19, 20, 21 | Key Performance Indicators (KPI) | Submit KPI Updates <ul style="list-style-type: none"> • Empanelment • Continuity • Third Next Available Appointment • Disparity Reduction <p><i>Note: achievement/improvement must be sustained over two consecutive submissions or met in the final submission.</i></p> | KPI Assessment |

November 2026 Milestones

Note: This will be the last opportunity to submit any un-submitted EPT deliverables.

| | 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 |

| | Category | Milestone | Deliverable |
|-----|---|--|--------------------|
| 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 |
| 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 |

| | Category | Milestone | Deliverable |
|-----|---|--|--------------------|
| 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.

Payment for MCP Produced EPT Milestones

(December 2025 Update) Four EPT milestones rely on MCP produced rates to assess practice performance. These include the three Population of Focus HEDIS-like milestones and the Assigned and Seen milestone. Since MCPs provide data to the Learning Center on a different schedule than the practice EPT submission cycles, and because HEDIS like data becomes available only at certain points in the year, reporting for these milestones will follow the schedule outlined in the chart below.

| MCP Reporting Cycle | MCP-Reported Data Available | HEDIS-like KPI Measurement / Reporting Period | Data to be sent by MCPs - YTD (incremental) | NCQA Specs | Assigned & Seen |
|---------------------|-----------------------------|---|---|------------|---------------------------------|
| A | 31-Oct-25 | CY 2024 | | 2024 | |
| A.1 | 31-Jan-26 | April 2024-Mar 2025 | Jan - Mar 2025 | 2024 | |
| B | 30-Apr-26 | July 2024-June 2025 | Jan - June 2025 | 2025 | 30-Apr-26 (MY 2024) |
| B.1 | 31-July-26 | Oct 2024-Sept 2025 | Jan - Sept 2025 | 2025 | |
| C | 31-Oct-26 | CY 2025 | Jan - Dec 2025 | 2025 | 31-Oct-26 (MY 2025) |
| C.1 | 31-Jan-27 | April 2025-Mar 2026 | Jan-Mar 2026 | 2025 | |
| D | 30-Apr-27 | July 2025-June 2026 | Jan - June 2026 | 2026 | 30-Apr-27 (July 2025-June 2026) |
| D.1 | 31-July-27 | Oct 2025-Sept 2026 | Jan - Sept 2026 | 2026 | |
| E | 31-Oct-27 | CY 2026 | Jan - Dec 2026 | 2026 | (MY 2026) |

EPT HEDIS-Like Measures

| Abbr | Measure | Pregnant | Adult Chronic | Adult Preventive | Children/ Youth | Behavioral |
|--------------|--------------------------------|----------|---------------|------------------|-----------------|------------|
| DSF-E | Depression screening - 12-17yo | | | | x | |

| | | | | | | |
|--------------|---|---|---|---|---|---|
| DSF-E | Follow-Up on Positive Screen - 12-17yo | | | | X | |
| DSF-E | Depression screening - Total | | X | X | | X |
| DSF-E | Follow-Up on Positive Screen - Total | | X | X | | X |
| PPC | Postpartum Care | X | | | | |
| PPC | Timeliness of Prenatal Care | X | | | | |
| PDS-E | Postpartum Depression Screening | X | | | | |
| PDS-E | Follow-Up on Positive Postpartum Depression Screen | X | | | | |
| COL-E | Colorectal Cancer Screening | | | X | | |
| BCS-E | Breast Cancer Screening | | | X | | |
| CCS | Cervical Cancer Screening | | | X | | |
| CBP | Controlling High Blood Pressure | | X | | | |
| HBD | Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%) | | X | | | |
| DRR-E | Depression Follow-Up | | | | | X |
| DRR-E | Depression Remission | | | | | X |
| DRR-E | Depression Response | | | | | X |
| POD | Pharmacotherapy for Opioid Use Disorder | | | | | X |
| CIS | Child Immunization Status – Combo 10 | | | | X | |
| W30 | 6 well child visits in first 15 months of life | | | | X | |
| W30 | 2 well child visits between 15 and 30 months of life | | | | X | |

| | | | | | | |
|------------|--|--|--|--|---|--|
| WCV | Well child visit between 3 and 21 years of age | | | | x | |
|------------|--|--|--|--|---|--|