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

Updated September 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 rates generated from MCP data. MCPs produce the three Population of Focus HEDIS®-like rates, while DHCS calculates the Assigned and Seen rate. Practices do not calculate or submit the Assigned and Seen rate. For details, see the reporting timeline below.

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 / DHCS	MCPs submit the HEDIS-like rates. DHCS calculates Assigned and Seen from MCP data; practices do not submit this rate.
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 14 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)**	**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 (PoF) stratified by race and ethnicity and at least one additional characteristic: primary spoken language, sexual orientation, gender identity, housing status, or disability status.	Stratified HEDIS®-like Measures Report

	Category	Milestone	Deliverable
18, 19, 20	**Key Performance Indicators (KPI)**	**Submit KPI Updates** • Empanelment • Continuity • Third Next Available Appointment *Note: achievement/improvement must be sustained over two (any two) submissions or met in the final submission.* 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.	KPI Assessment

November 2025 Milestones

	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

	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: • 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 any two submissions or met in the final submission.*	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**	**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: 1. Depression screening • Percent of population of focus screened with PHQ-2/PHQ-9 • Percent of patients with positive screening who are linked to services 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 b. Percent of patients linked to services with a close looped referral	Workflow and Metric Reporting
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:	Workflow and Metric Reporting

		• 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** • Empanelment • Continuity • Third Next Available Appointment • Disparity Reduction *Note: achievement/improvement must be sustained over any two submissions or met in the final submission.*	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 *any two* 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 *any two* 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 *any two* 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 *any two* submissions or met in the final submission.	KPI Assessment
22.	**DHCS Key Performance Indicators (KPI)** **Updated September 2026**	Assigned and seen in a 12-month period. DHCS calculates this rate using MCP enrollment, PCPA assignment, and claims and encounter data. Practices do not submit the rate.	DHCS calculated
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 *any two* 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 *any two* 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 *any two* 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

***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 and DHCS Calculated EPT Milestones

(September 2026 Update) MCPs produce the three Population of Focus HEDIS-like rates. DHCS will calculate Assigned and Seen using MCP enrollment, assignment/PCPA, and claims and encounter data under the EPT variant technical specifications. The site-level rate reflects assigned members who had at least one qualifying primary care visit during the specified 12-month measurement period at any NPI associated with the assigned organization. Practices do not calculate or submit this rate.

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	