Quality Incentive Pool (QIP) Program

Calendar Year 2026 (CY2026)

QIP General Guidelines for QIP Data Collection and Reporting

RELEASED DECEMBER 15, 2025

Applies to Measurement Period January 1–December 31, 2026

DHCS has approved this QIP Reporting Manual for the sole purpose of facilitating the participation of qualified entities in the QIP program, pursuant to the applicable *Directed Payments QIP, Section 438.6(c) Preprint.* Note that guidelines in this Manual may change if required for CMS approvals applicable to this program. The continuation of this program is subject to, and contingent upon, CMS approval.

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GENERAL GUIDELINES FOR QIP DATA COLLECTION AND REPORTING

VII. ABOUT THE GENERAL GUIDELINES FOR QIP DATA COLLECTION AND REPORTING SECTION

The *General Guidelines for QIP Data Collection and Reporting,* a resource for QIP managers and reporting leads, highlights key information for reporting QIP performance measures.

Citations from DHCS policy documents not included in the guidelines are in quotes, and the relevant policy document is listed as the source. Text that is not in quotes paraphrases cited documents or is additional DHCS guidance.

A. CY2026 DOCUMENT CONTROL LOG: QIP GENERAL GUIDELINES

Modifications from CY2025 Manual

- Updated all dates and references to CYs.
- Removed all references to CY2025 (formerly PY8).
- Added instructions to download the Direct Reference Codes excel file to section VIII. B. ECQM Value Sets.
- Removed measures with specific guidance from section VIII. F. Paid, Suspended, Partial, Pending, and Denied Claims, because this guidance was added to the individual measure specifications.
- Removed Target Population B from Section X as it is no longer applicable to any of the QIP measures. The remaining target populations will maintain their nomenclature for CY2026 (e.g., Target Population C from CY2025 will remain Target Population C in CY2026.)
- Updated Table 8 in section XI. Use of Non-Entity Service Data.
- Moved section XIV. B. Stratification of Reported Data by Race and Ethnicity to Appendix 6.

VIII. MEASURE CODING

Specifications for QIP measures may refer to value sets, the Medication List Directory (MLD), and/or National Drug Code (NDC) lists, which are maintained by the measure steward. The source and instructions for obtaining these code sets is included in each applicable measure section below. Measures and/or measure types without external code sets are as follows.

A. HEDIS VALUE SETS AND MEDICATION LIST DIRECTORY

HEDIS specifications and value sets can be obtained at the **NCQA Store** under "HEDIS Volume 2: Technical Specifications for Health Plans." Refer to the HEDIS Volume 2 MY 2026 specifications and value sets (including the MY 2026 Technical Update, which includes updates that must be incorporated for CY2026 reporting) for the CY2026 version of the QIP Reporting Manual.

QIP entities that purchase HEDIS MY 2026 Volume 2 prior to March 31, 2026, must redownload the Value Set Directory file for MY 2026 after the MY 2026 Technical Update is released on March 31, 2026, via **https://my.ncqa.org/**.

The HEDIS MY 2026 MLD list is available on **NCQA's MY 2026 MLD website**.

Identifying HEDIS Code and Value Set Changes

Changes to HEDIS codes and value sets can be found in the HEDIS Value Set Directory file under the following tabs: **Summary of Changes – Value Sets and Summary of Changes – Codes.**

The **Summary of Changes – Value Sets** tab lists HEDIS value set changes, and includes the elements in Table 6.

Table 6. Value Set Summary of Changes Elements

Element Name	Element Description
Value Set Name	The name of the affected value set.
Change	The change (Added to; Deleted from).
Description	Describes the affected measure or, for renamed value sets, the new value set name.
Revised	August 1 release changes are identified by a revised date of 2025-8-01.

The **Summary of Changes – Codes** tab lists the HEDIS code changes by value set and includes the elements in Table 7.

Table 7. Code Summary of Changes Elements

Element Name	Element Description
Value Set	The name of the value set affected by the change.
Change	The change (Added; Deleted).
Code System	The code system for the code.
Code	The code.
Revised	August 1 release changes are identified by a revised date of 2025-8-01.

B. ECQM VALUE SETS

Value sets for eCQMs listed in this QIP Reporting Manual can be found at the **National Library of Medicine Value Set Authority Center (VSAC)**. To access the value sets, users must obtain a free **Unified Medical Language System® Metathesaurus License (UMLS)**.

To access the correct version of the value sets on the VSAC website:

- Click the **Download** tab.
- Select the corresponding version of the value sets to the eCQM version in the QIP Manual. Because the CY2026 version of the manual uses eCQM 2026, select: "2026 Reporting/Performance Period of eCQM & Hybrid Measure Value Sets."

- Select the final version of value sets that align with eCQM 2026: "May 2025 Release eCQM & Hybrid Measure Value Sets Publication Date: May 08, 2025."
- A table of value sets and direct reference codes to download will display, and QIP entities can download the Excel file listed under the following rows in the "Sorted by CMS ID" column:
  - eCQM Value Sets for Eligible Clinicians Published May 08, 2025.
  - eCQM Value Sets for Eligible Hospitals Published May 08, 2025.
  - Direct Reference Codes Specified within eCQM HQMF files Published May 08, 2025.

Identifying eCQM Value Set Changes

Follow these instructions to find a list of eCQM value set updates.

- Go to the Eligible Clinician eCQMs page on the **eCQI Resource Center website**.
- Locate the corresponding eCQM by clicking the **eCQMs** tab and then selecting "2026" from the Select Period drop-down menu.
- Click the corresponding measure name, click the **Release Notes** tab, and scroll down to the "Value Set" section, which will indicate the detailed value set updates to the latest version of the eCQM. These updates will also be noted in the "Summary of Changes from CY2025 Manual" section at the top of most eCQM measures in the Manual.

C. CMS CORE SET VALUE SETS

Value sets for the CMS Child Core Set measures can be found **here** *(email **MACQualityTA@cms.hhs.gov** for "2025 Child Core Set HEDIS Value Set Directory" and "2025 Child Core Set Non-HEDIS Value Set Directory" if the files are no longer available on the website).*

Value sets for the CMS Adult Core Set measures can be found **here** *(email **MACQualityTA@cms.hhs.gov** for "2025 Adult Core Set HEDIS Measures Value Set Directory" and "2025 Adult Core Set Non-HEDIS Measures Value Set Directory" if the files are no longer available on the website).*

D. OPIOID NDC LISTS

The Opioid NDC lists for **Q-COB** and **Q-OHD** are publicly available via links in the measure specifications.

E. MAPPING PROPRIETARY AND OTHER CODES

Code Mapping Not Allowed

- ***Standard codes.*** Standard codes not used in a measure may not be mapped to standard codes used in a QIP measure. For example, if LOINC codes are not used in a measure, LOINC codes may not be mapped to CPT codes in the measure. Similarly, a specific CPT code not used in a measure may not be mapped to a CPT code included in the measure. For QIP mapping, standard codes include any code in a measure specification's value sets; for example, POS, CPT, CVX, HCPCS, ICD-9-CM/PCS, ICD-10-CM/PCS, LOINC, SNOMED CT,[1] UBTOB, and RxHCC.
- ***Deleted codes.*** Deleted codes (removed from a measure) may not be mapped to standard codes used in the QIP Manual measures.

Code Mapping Allowed

QIP entities may map the following categories for QIP reporting, as per these instructions:

- Health care services documented in the health record[2] matching the clinical specificity of the codes required for the measure.
- A medication in a patient's health record that is not represented by an NDC or RxNorm code in the HEDIS MLD, or the VSAC for eCQM measures, may only be mapped if its generic name (or brand name), strength/dose, and route documented in the health record match those of a code in the MLD.
- If a patient has been given an immunization represented by an NDC code or other (non-NDC code) documentation in the health record, and the immunization is the same (in all aspects) as an immunization represented by an NDC in a value set, the immunization in the health record may be mapped to the immunization in the value set.
- Clinical outcomes that do not have specific codes (e.g., A1c <8 evidence, which requires a combination of lab code and lab result, reporting of a point of service lab result).
- Proprietary, state-, or institution-specific codes used to determine compliance with the measures' numerator, denominator, and exclusions.

[1]SNOMED codes are considered supplemental data for HEDIS measures.

[2]Health record data refers to all information (records and documents), on paper or in electronic form, pertaining to patient care, to which the QIP entity has access (i.e., stored and/or retrievable by the entity).

If the QIP Manual measure-specified coding systems are not documented in the QIP entity health record, the entity determines compliance with the measure's numerator, denominator, and exclusions, by "mapping" the institution-specific codes or workflows to the codes specified for the relevant measures.

Note: Codes must be mapped consistently across all measures. When mapping codes, match the clinical specificity required for the measure.

QIP entities must have auditable documentation of the mapping process. To support this auditable process, QIP entities should be prepared to submit documentation that includes a crosswalk containing the relevant mapped codes, descriptions, and clinical information, if requested by DHCS. It is also recommended that QIP entities document the policies and procedures and workflows used to map institution-specific codes to the codes specified in the measure.

QIP entities are strongly encouraged to review the DHCS document **Quality Measures for Encounter Data** (August 8, 2018) to understand DHCS expectations for submission of encounter data.

F. PAID, SUSPENDED, PARTIAL, PENDING, AND DENIED CLAIMS

For most measures, the QIP entity must include all paid, suspended, pending, partial, and denied claims. The entity is ultimately responsible for the quality of care it provides to individuals.

Unless otherwise specified in the measure, entities may choose to include reversed claims when reporting services. Claims must be included in all measures in this case, and may not be double counted (e.g., if a subsequent claim is filed, use only the corrected or adjudicated claim).

G. TELEHEALTH ALLOWANCES AND GUIDANCE

Additional guidance related to telehealth is available for some measures used in QIP CY2026, including HEDIS, eCQMs, and CMS Adult and Child Core Set measures. A summary of this guidance is below.

HEDIS

Synchronous telehealth requires real-time interactive audio and video telecommunication.

Asynchronous telehealth, sometimes referred to as an "e-visit" or "virtual check-in," is not in "real-time" but still requires two-way interaction between the person and provider. For example, asynchronous telehealth can occur through a patient portal, secure text messaging, or email.

A measure specification that is silent about telehealth includes telehealth because telehealth is billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier and/or telehealth POS code. Therefore, the CPT or HCPCS codes in the applicable value sets will meet criteria (regardless of the presence of a telehealth modifier or POS code). QIP entities should review the codes in the value sets to identify whether telehealth is included in a measure.

eCQMs

Find telehealth guidance for 2026 eCQMs on the **eCQI Resource Center website**.

Q-CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan is not eligible for telehealth encounters, as described in this resource.

All other 2026 eCQMs used in the QIP CY2026 Manual are eligible for telehealth encounters. QIP entities are responsible for reviewing measure specifications and adhering to the types of telehealth encounters that are eligible for each aspect of the measure (e.g., denominator, numerator, exclusions).

CMS Adult and Child Core Set

Find telehealth guidance for 2025 CMS Adult and Child Core Set measures at **Medicaid.gov**.

There are no specific telehealth restrictions for any 2025 Adult and Child Core Set measures in QIP CY2026. The document should be reviewed for further details on each measure.

IX. INCLUSION OF NON-CLINICIAN CARE TEAM MEMBER

Unless already delineated in the measure specifications, the QIP entity determines the appropriate care team member(s) to conduct a service measured by each QIP measure, including both in-person and virtual services. If selected care team members are not licensed to practice independently, the QIP entity ensures that they have had the appropriate supervision and training to provide the service and will maintain the appropriate level of documentation of services provided.

X. QIP TARGET POPULATIONS

QIP Target Populations describe the payer criterion that is the starting point for each measure prior to applying denominator criteria. Each measure includes the Target Population in the measure header as well as in a separate section in the measure body.

Continuous Assignment and Continuous Enrollment Criteria
For QIP reporting, patients are attributed in the following ways, as specified by each measure:

- *Continuous assignment to a QIP entity:* Continuous assignment specifies the minimum amount of time a patient must be assigned to the QIP entity before becoming eligible for a measure*.*
- *Continuous enrollment to an MCP:* Continuous enrollment specifies the minimum amount of time a patient must be enrolled in the MCP before becoming eligible for a measure.

Refer to **Section XIV. B. Stratification of Reported Data by Medi-Cal Health Plan** for reporting patients based on MCP enrollment and QIP entity assignment.

Definition of "Persons with Other Health Coverage"
"Persons with other health coverage" are defined as "Persons with a non-Medi-Cal primary insurance (e.g., Medicare or private insurance) with Medi-Cal as a secondary payer (either Medi-Cal Fee for Service or Medi-Cal Managed Care Plan)."

The following target populations are used in QIP.

- **Target Population A:** Medi-Cal Managed Care (MCMC) beneficiaries assigned to the QIP entity and meeting measure specific continuous assignment criteria: For a contracted MCMC Plan, a beneficiary meets the measure-specific continuous assignment criteria. For DMPHs with DHCS approved community partners only, this must include patients who meet measure-specific continuous assignment criteria with community partners, for allowable QIP community partner measures.
  - If reporting an MCMC assigned lives measure, the QIP entity must choose to either include all or exclude all MCMC assigned persons with other health coverage, according to CY2024 guidance, which may include dually eligible enrollees, as defined in state and federal law, for at least one month of the CY. The QIP entity must include or exclude such persons for each given measure in every CY moving forward (i.e., for any given measure, the entity may not include such persons one CY and then exclude them in the next CY, or vice versa). There will be no exceptions, and the entity will not be able to change its decision in future CYs.
  - For the Q-PCR measure, QIP entities must exclude all MCMC assigned persons with other health coverage for at least one month of the CY.
  - For the Q-ECM measure, use a Modified Target Population A. A person must have at least six months of continuous assignment to the QIP entity in the measurement period, and must meet ECM Population of Focus (POF) eligibility criteria during the measurement period to be included.
  - For the Q-COMS measure, use a Modified Target Population A. A person must have at least six months of continuous assignment to the QIP entity in the measurement period, and was referred to at least one Community Support during assignment to the QIP entity to be included.

- **Target Population C:** MCMC beneficiaries with 12 months of continuous assignment to the QIP entity during the CY, ***OR*** persons enrolled in Medi-Cal (Managed Care or Fee for Service) on the date of a QIP entity primary care or HIV specialty care denominator encounter (Q-CMS314: *HIV Viral Suppression*).
  - A QIP entity must include **all** persons with other health coverage, which may include dually eligible enrollees, as defined in state and federal law, **in both target populations** (i.e., such persons must be included for both the "Assigned Lives" target population AND from the "Enrolled in Medi-Cal" target population). A person who meets both populations should only be reported once in either population to avoid duplication.
    - Include continuously assigned MCMC persons with other health coverage, which may include dually eligible enrollees, as defined in state and federal law, for at least one month of the CY.
    - For the "Enrolled in Medi-Cal" part of the target population, include persons with other health coverage, which may include dually eligible enrollees, as defined in state and federal law, on the date of the denominator event.
- **Target Population D:** Enrolled in Medi-Cal (Managed Care or Fee for Service) on the date of the QIP entity denominator event. The beneficiary was enrolled in Medi-Cal Fee for Service or enrolled with a specific MCP on the date of the measure specified event (e.g., encounter, procedure, ED visit), which must have occurred at the QIP entity.
  - Include all Medi-Cal beneficiaries with other health coverage, which may include dually eligible enrollees, as defined in state and federal law, on the date of the denominator event.
  - For the Q-FUM, Q-FUA, Q-FUI, and Q-FUAH measures, use the Modified Target Population D. Entities must exclude Medi-Cal Fee for Service, and either include or exclude persons enrolled in "out-of-county" MCPs according to their CY2024 reports.
- **Target Population E:** On the date of the measure specified event (e.g., encounter, procedure) the person was (1) uninsured, (2) had Medi-Cal primary insurance (either Medi-Cal Fee for Service or Medi-Cal Managed Care Plan), or (3) had a non-Medi-Cal primary insurance (e.g., Medicare or private insurance) with Medi-Cal as a non-primary payer (either Medi-Cal Fee for Service or Medi-Cal Managed Care Plan).
- **Target Population F:** Payer agnostic. All persons (regardless of payer, continuous assignment, or continuous enrollment) are included in this population.

Type of Medi-Cal

The definitions for "enrolled in Medi-Cal Managed Care" and "enrolled in Medi-Cal Fee for Service" are below. Note that persons with Medi-Cal Fee for Service may not be enrolled in managed care because there is no managed care plan.

- *Enrolled in Medi-Cal Managed Care:* Services provided to a person who is enrolled in a Medi-Cal managed care plan. Persons enrolled in a D-SNP combined Medi-Cal and Medicare managed care plan are included in this definition. Managed care plan payments may be Fee for Service payments or through capitation arrangements.
- *Enrolled in Medi-Cal Fee for Service:* Services provided to persons who are enrolled in Medi-Cal, but not enrolled in a Medi-Cal managed care plan. Payments to providers for services under "Medi-Cal Fee for Service" are fee for service payments made by the State or the State's fiscal intermediary. Specifically, if an individual has both private or Medicare coverage AND Medi-Cal Fee for Service, because Medi-Cal is always a payer of last resort, the provider will likely not receive Medi-Cal payments for services. However, these persons are still "enrolled in Medi-Cal Fee for Service" when determining eligibility for denominator inclusion.

XI. USE OF NON-ENTITY SERVICE DATA

For Q-AAB, Q-URI, and Q-LBP, numerator compliance (Q-LBP only) and denominator inclusion should be calculated by QIP entities using data only from services and encounters that occurred at the QIP entity's facilities, with the exception that QIP entities must use all data (including non-entity data) to which they have access in order to determine Negative Medication, Comorbid Condition, and Competing Diagnosis Histories.

For Q-PCE, Q-FUA, Q-FUI, Q-FUM, and Q-TRC, denominator inclusion should be calculated by QIP entities, using data only from encounters that occurred at the QIP entity's facilities, with the exception that for Q-PCE, Q-FUI, Q-FUM, and Q-TRC, QIP entities must use all data (including non-entity data) to which they have access in order to identify and exclude QIP entity discharges that resulted in direct transfers to non-entity facilities.

Table 8: Inclusion of Non-Entity Service Data by Measure

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
Q-AIS-E	Adult Immunization Status	Yes, only for denominator exclusions	Yes
Q-QPP47	Advance Care Plan	No	No Advance Care Plans obtained from a non-QIP entity but accessible in the QIP entity health record during the measurement year are allowed

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
Q-URI	Appropriate Treatment for Upper Respiratory Infection	Yes, only for negative medication and comorbid condition history and competing diagnosis histories	No A numerator compliant medication dispensed by a non-QIP entity is allowed if documented in the patient's current medication list or accessible in the QIP entity health record during the measurement year
Q-AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	Yes, only for negative medication and comorbid condition history, and competing diagnosis histories	No A numerator compliant medication dispensed by a non-QIP entity is allowed if documented in the patient's current medication list or accessible in the QIP entity health record during the measurement year
Q-BCS-E	*Breast Cancer Screening	Yes, only for denominator exclusions	Yes
Q-CCS-E	*Cervical Cancer Screening	Yes, only for denominator exclusions	Yes
Q-PC02	*Cesarean Birth	No	No
Q-WCV	*Child and Adolescent Well-Care Visits	Yes, only for denominator exclusions	Yes
Q-CIS-E	*Childhood Immunization Status	Yes, only for denominator exclusions	Yes
Q-CHL	*Chlamydia Screening in Women	Yes	Yes
Q-COB	Concurrent Use of Opioids and Benzodiazepines	Yes	Yes
Q-COL-E	*Colorectal Cancer Screening	Yes, only for Assigned Lives	Yes
Q-CBP	*Controlling High Blood Pressure	Yes	Yes
Q-QPP118	Coronary Artery Disease: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	No	No A numerator compliant medication prescribed by a non-QIP entity provider is allowed if documented in the patient's current medication

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
	for Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)		list or accessible in the QIP entity health record during the measurement year
Q-QPP6	Coronary Artery Disease: Antiplatelet Therapy	No	No A numerator-compliant medication prescribed by a non-QIP entity provider is allowed if documented in the patient's current medication list or accessible in the QIP entity health record during the measurement year
Q-DRR-E	Depression Remission or Response for Adolescents and Adults	Yes	Yes
Q-DSF-E	*Depression Screening and Follow-Up Plan	Yes, only for denominator exclusions	Yes
Q-DEV	*Developmental Screening in the First Three Years of Life	No, because the denominator is only based on individual's age	Yes
Q-STK-2	Discharged on Antithrombotic Therapy (STK-2)	No	No
Q-QPP415	Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	No	No
Q-PC05	Exclusive Human Milk Feeding (PC-05)	No	No
Q-EED	Eye Exam for Patients With Diabetes	Yes	Yes
Q-FUA	*Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence	Yes, only for denominator exclusions	Yes
Q-FUM	*Follow-Up After Emergency Department Visit for Mental Illness	Yes, only for denominator exclusions	Yes

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
Q-FUI	Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Yes, only for identifying exclusions and excluding QIP entity discharges that result in direct transfers	Yes
Q-GSD	*Glycemic Status Assessment for Patients With Diabetes	Yes	Yes
Q-CMS135	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	No	No A numerator-compliant medication prescribed by a non-QIP entity provider is allowed if documented in the patient's current medication list or accessible in the QIP entity health record during the measurement year
Q-CMS349	HIV Screening	Yes	Yes
Q-CMS314	HIV Viral Suppression	Yes, only for Assigned Lives	Yes
Q-HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems	No	No
Q-IMA-E	*Immunizations for Adolescents	Yes, only for denominator exclusions	Yes
Q-IHE1	*Improving Equity #1	Refer to parent measure	Refer to parent measure
Q-IHE2	Improving Equity #2	Refer to parent measure	Refer to parent measure
Q-KED	Kidney Evaluation for Diabetes (KED)	Yes	Yes
Q-LSC-E	Lead Screening in Children	Yes, only for denominator exclusions	Yes
Q-COMS	Number of and Percentage of Eligible Individuals Receiving Community Supports, and Number of Unique Community Supports Received by Individuals	Yes	Yes
Q-ECM	Number of Individuals Enrolled in ECM	Yes	Yes

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
Q-FUAH	Percentage of acute hospital stay discharges that had follow-up ambulatory visits within 7 days post hospital discharge	Yes, only for direct transfers and denominator exclusions	Yes
Q-QPP23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	No	No
Q-POD	Pharmacotherapy for Opioid Use Disorder (POD)	Yes	Yes
Q-PCE	Pharmacotherapy Management of COPD Exacerbation	Yes, only for identifying exclusions and excluding QIP entity discharges that result in direct transfers	Yes
Q-PCR	Plan All-Cause Readmissions	Yes, only for direct transfers and outliers	Yes
Q-PPC-Pst	*Prenatal and Postpartum Care (Postpartum Care)	Yes	Yes
Q-PPC-Pre	*Prenatal and Postpartum Care (Timeliness of Prenatal Care)	Yes	Yes
Q-PND-E	Prenatal Depression Screening and Follow-Up	Yes	Yes
Q-PRS-E	Prenatal Immunization Status (PRS-E)	Yes	Yes
Q-PDS-E	Postpartum Depression Screening and Follow-Up	Yes	Yes
Q-QPP76	Prevention of Central Venous Catheter (CVC) Related Bloodstream Infections	No	No
Q-CMS69	Preventive Care and Screening: Body Mass	Yes, only for denominator exclusions	No

QIP Measure ID	Measure Name (*Priority Measure)	Inclusion of Non-Entity Services for Denominator	Inclusion of Non-Entity Services for Numerator
	Index (BMI) Screening and Follow-Up Plan		
Q-CMS138	*Preventive Care and Screening: Tobacco Assessment and Counseling	No	No
Q-CDI	Reduction in Hospital Acquired C Difficile Infections	No	No
Q-CMS347	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Yes	Yes
Q-SSI	Surgical Site Infection	No	No
Q-TRC	Transitions of Care	Yes, only for identifying exclusions and excluding QIP entity discharges that result in direct transfers	No
Q-LBP	Use of Imaging Studies for Low Back Pain	Yes, only for Negative Diagnosis History and denominator exclusions	No
Q-OHD	Use of Opioids at High Dosage in Persons Without Cancer	Yes	Yes
Q-WCC	Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents	Yes	Yes
Q-W30	*Well-Child Visits in the First 30 Months of Life	Yes, only for denominator exclusions	Yes

XII. ELIGIBLE POPULATION EXCLUSIONS

For all measures with continuous assignment criteria, MCMC beneficiaries who fit in any category below may be excluded prior to determining a measure's QIP eligible population. Exclusions must be applied consistently across all applicable measures.

Note: The exclusions below only apply to measures with Target Population A.

1. **Retroactive Eligibility.** Persons for whom the retroactive eligibility period is longer than one month during the QIP CY should be excluded from measure denominators. The retroactive eligibility period is the elapsed time between the

date when the eligibility organization became financially responsible for the Medi-Cal beneficiary and the date when it received notification of the new beneficiary.

2. **Non-Certified Eligible Persons**. Medi-Cal managed care beneficiaries for whom non-certified enrollment is longer than one month during the QIP CY should be excluded from measure denominators. Non-certified enrollment months are months when the beneficiary did not receive Medi-Cal benefit coverage (e.g., from unmet share of cost).
3. **Deceased Patients.** Patients who died during a measure's applicable continuous assignment period should be excluded if the QIP entity is aware of the patient's death prior to reporting, unless additional guidance is provided in a measure specification. The QIP entity must also notify the patient's MCP of the death, and include in its data methodology narrative the number of patients who were removed from the measure denominator for this reason.
4. **Persons with Other Health Coverage.** Medi-Cal beneficiaries for whom Medi-Cal is not the primary payer. Only some measures allow exclusion of these beneficiaries. Refer to **Section X. QIP Target Populations** for target population-specific exclusion criteria.

XIII. SAMPLING

This section contains guidelines for sampling based on measure type.

If the QIP entity chooses to pursue the Hybrid/Medical Record Review Method for applicable measures, it is required to indicate if sampling was used in the data methodology narrative on the QIP Reporting Application. Information on the number of persons in the Total Population before sampling should also be included in the data methodology narrative. The QIP entity is encouraged to submit as many cases as possible, up to the entire population of cases, if feasible. If raw data can be easily extracted from an electronic database, or if the abstraction burden is manageable, the QIP entity should submit the entire population of cases that meet the initial selection criteria; otherwise, a statistically valid sample may be selected.

If the QIP entity samples, it must use the health records from cases in the randomly identified sample. If a measure population size is less than the minimum number of cases for the sample size, sampling may not be used, as determined by DHCS. Sampling must be done after the end of the CY.

If the QIP entity does not sample, it should use all health records identified in the population. Sampling is not allowed for measures reported only using the Administrative Method or the ECDS Method.

QIP entities should follow the guidelines on supporting documentation in **Section V. F. QIP Data Integrity Policy**. Documentation may be used to support an audit, as outlined in **Section V. F. QIP Data Integrity Policy**.

Table 9 includes a summary of guidance on sampling by measure type.

HEDIS and CMS Adult and Child Core Set

HEDIS and CMS Adult and Child Core Set measures in the QIP CY2026 Manual may include one or more of the three data collection methods listed in Table 9.

Table 9: HEDIS and CMS Adult and Child Core Set Sampling Guidance

Data Collection Method	Measure Type	Sample Guidance
Administrative Method	HEDIS and CMS Adult and Child Core Set	QIP entities must report denominators that are based on the entire eligible population; **sampling is not allowed**.
Hybrid Method	HEDIS and CMS Adult and Child Core Set	QIP entities may report denominators that are based on a systematic sample of persons drawn from the eligible population; **sampling is allowed**. Table 10 lists the hybrid specifications included in the QIP measure set.
Electronic Clinical Data Systems (ECDS) Method	HEDIS	QIP entities must report denominators that are based on the entire eligible population; **sampling is not allowed**.

Table 10: Hybrid Specifications Included in the QIP Measure Set

Hybrid Specifications Included in the QIP Measure Set
Q-DEV: *Developmental Screening in the First Three Years of Life
Q-WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
Q-CBP: *Controlling High Blood Pressure (CBP)
Q-GSD: *Glycemic Status Assessment for Patients with Diabetes (>9.0%) (HBD)
Q-TRC: Transitions of Care (TRC) • Patient Engagement After Inpatient Discharge • Medication Reconciliation Post-Discharge
Q-PPC-Pre: *Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-PRE)
Q-PPC-Pst: *Prenatal and Postpartum Care: Postpartum Care (PPC-PST)
Q-PC05: Exclusive Human Milk Feeding

eCQMs

eCQMs use data electronically extracted from electronic health records (EHRs) and/or health information technology systems to measure the quality of health care provided. QIP entities reporting eCQM measures must report denominators that are based on the entire eligible population. **Sampling is not allowed**.

MIPS CQMs

MIPS CQMs use transaction data such as enrollment, claims, encounters, and supplemental. QIP entities reporting MIPS CQM measures must report denominators that are based on the entire eligible population. **Sampling is not allowed**.

Other Measure Types

Table 11 includes guidance on sampling for the remaining measure types in the QIP CY2026 Manual.

Table 11: Sampling Guidance for Other Measure Types

Measure Name	Measure Type	Sample Guidance
Improving Health Equity 1	DHCS	Refer to the selected Eligible Equity measure's QIP specification for sampling guidance.
Improving Health Equity 2	DHCS	Refer to the selected Eligible Equity measure's QIP specification for sampling guidance.
Exclusive Human Milk Feeding (PC-05)	The Joint Commission	Sampling is allowed; refer to guidelines in the specifications.
*Cesarean Birth (PC-02)	The Joint Commission	Entire eligible population; **sampling is not allowed**.
Reduction in Hospital Acquired Clostridium Difficile Infections	Centers for Disease Control and Prevention National Healthcare Safety Network	Entire eligible population as reported via NHSN; **sampling is not allowed**.
Surgical Site Infection (SSI)	National Healthcare Safety Network/CA Department of Public Health	Entire eligible population as reported via NHSN; **sampling is not allowed**.

A. SAMPLE SIZE

As a general rule, sample size requirements are based on commonly accepted sampling criteria:

- A 5 percent margin of error is recommended.
- The size of the population, also referred to as the "universe population," is the volume of eligible records from which the sample is drawn. Refer to **Table 12: Sample Sizes** for sample size requirements per population size.
- Because the number of cases in the sample could be further reduced during the analysis phase due to missing data in the health records and additional measure exclusion criteria, participating QIP entities are strongly advised to overestimate the sample size by 10 percent to 20 percent, or as much as possible.
- A quality check is recommended to ensure that the sampling methodology was applied correctly. Participating QIP entities should run a basic comparative analysis of common demographic variables (e.g., age, gender ratio, race, ethnicity) between

the sampled set and the population of eligible patients. The relative frequency or distribution of these common variables should be very close.

- Participating QIP entities may choose to use a larger sample size than is required.

B. RANDOM SAMPLING

To obtain statistically valid sample data, sample cases should be randomly selected in such a way that individual cases in the population have an equal chance of being selected, and thus represent the whole population.

The participating QIP entity may use either simple random sampling or systematic random sampling:

- *Simple random sampling:* Select a sample size (n) from a population of size (N) in such a way that every case has the same chance of being selected.
- *Systematic random sampling:* Select every kth record from a population size (N) in such a way that a sample size (n) is obtained, where k = N/n is rounded to the lower digit. Before taking the kth record, the first sample record or starting point must be randomly selected by choosing a number between 1 and k, using a table of random numbers or a computer-generated random number.

Table 12: Sample Sizes

Annual Population Size (N)	Annual Sample Size (n)	Annual Population Size (N)	Annual Sample Size (n)
≤80	Use all cases	401-425	203
81-100	80	426-450	208
101-125	95	451-500	218
126-150	109	501-600	235
151-175	121	601-700	249
176-200	132	701-800	260
201-225	143	801-900	270
226-250	152	901-1,000	278
251-275	161	1,001-2,000	323
276-300	169	2,001-3,000	341
301-325	177	3,001-4,000	351
326-350	184	4,001-5,000	357
351-375	191	5,001-10,000	370
376-400	197	≥10,001	377

C. PROPORTIONATE SAMPLING

If a QIP entity chooses to sample, and data are available electronically for one part of the entity and available only in paper charts for another, the entity may use proportionate sampling. The sample should be based on the total population of qualifying cases from both electronic and paper sources across the entire QIP entity. The proportion of cases to be sampled electronically is equal to the proportion of electronic cases in the total population. The same applies to paper charts.

For example, the total population is 10,000. 8,000 cases have an electronic data source. 2,000 cases have paper charts as the only data source. Per **Table 12**, the sample size should be at least 377. If the QIP entity oversamples for a sample of 450 patients, the entity can sample 360 cases from the electronic data source and 90 cases from the paper charts. Sampling should adhere to the random sampling principles specified above.

XIV. QIP REPORTING MECHANISM

A. REPORTING MECHANISM

QIP entities report data as specified by DHCS, and are expected to report data stratified by Medi-Cal managed care plans, as specified in **Section XIV. B. Stratification of Reported Data by Medi-Cal Health Plan**.

B. STRATIFICATION OF REPORTED DATA BY MEDI-CAL HEALTH PLAN

Report all QIP measures as a single QIP entity rate. Also report all measures (with the exceptions of *Q-CDI: Reduction in Hospital Acquired C Difficile Infections, Q-SSI: Surgical Site Infection,* and *Q-HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems*), stratified by enrollment in Medi-Cal MCP and by enrollment in Medi-Cal Fee for Service, according to the type of Medi-Cal in which each measure's denominator patients are enrolled in the QIP CY. Below is an example of a measure stratified by a Medi-Cal health plan in the QIP Reporting Application.

	Baseline	Target Rate	Numerator	Denominator	Achievement Rate	Achievement Value	Next CY Target Rate
Aggregate Rate	0	0.4807	180	385	0.4675	0	0.4820
MCP Generic Name 1			100	200	0.5000		
Other Medi-Cal MCP(s)			50	75	0.6667		
Medi-Cal Fee For Service			25	100	0.2500		
Beneficiaries continuously assigned to QIP Entity but switched MCP			5	10	0.5000		

Refer to **Section X. QIP Target Populations** for definitions of "Type of Medi-Cal."

When reporting each measure's Medi-Cal stratified denominator data, only include patients who meet each measure's payer population. Refer to **Section X. QIP Target Populations** for definitions.

If a beneficiary was continuously assigned to the QIP entity through MCMC for the entire measure specified continuous assignment period, but switched MCP mid-year, and thus did not meet the continuous enrollment criteria for any contracted MCP, include the data for these beneficiaries in the "Beneficiaries continuously assigned to the QIP entity but switched MCP" row.

XV. MEASURE QUESTIONS PROCESS

For questions regarding **QIP measure specifications** and **QIP reporting**, QIP entities should first review previously answered QIP measure specification and reporting questions by accessing the QIP PCS Report on the DHCS QIP SharePoint site, **eQIP**, and for DPHs at **SNI Link/QIP**.

For **measure** questions that are not answered in the QIP PCS Report, QIP entities should submit questions directly to PCS (refer to **Appendix 2** for instructions). Responses to measure questions are posted in **eQIP** (NCQA Measure Policy Guidance).

For **non-measure** QIP questions, QIP participating entities should contact their QIP Liaison at **QIP@dhcs.ca.gov,** or contact their respective association. DPH participating entities should contact SNI (Dr. Ash Amarnath, **aamarnath@caph.org**; Arlene Marmolejo, **amarmolejo@caph.org**); DMPH participating entities should contact DHLF (Charity Bracy, **cbracy@umich.edu**).

XVI. STANDARD QIP SUMMARY OF CHANGES FROM CY2025 MANUAL

A. ALL SPECIFICATIONS

- Updated all dates to align with the QIP CY2026 reporting period and source specifications.
- Removed references to CY2025 reporting.

B. HEDIS SPECIFICATIONS

- Updated the formatting of all HEDIS measures to align with the FHIR® standard. These changes are intended to enable future interoperability of human-readable technical specifications, and do not modify the intent or calculation of a measure.
  - Added measurement period, clinical recommendation statement/rationale and characteristic sections.
  - Updated terminology (replaced "Measurement year" with "measurement period"; "individuals" with "persons"; "eligible population" with "initial population"; "required exclusions" with "denominator exclusions").
  - Reformatted the initial population section. Attribution now describes continuous assignment to QIP entity criteria.
  - Removed medication lists, where applicable. This information can be found in the HEDIS Medication List Directory (MLD). The medication list tables remain only in measures where the information in the tables is required for measure calculation.

C. MIPS ECQM SPECIFICATIONS

- Updated the names of CQL definitions, functions, and/or aliases for clarification and to align with the CQL Style Guide"
- Updated the eCQM version number.
- Changed the 'eCQM Identifier (Measure Authoring Tool)' field name to 'CMS ID' based on tooling updates.
- Updated the version number of the Global Shared Library to v9.0.000 and the library name from 'MATGlobalCommonFunctionsQDM' to 'CQMCommonQDM' in the logic section.

D. MIPS CQM SPECIFICATIONS

- Updated measure flow narratives.

E. CMS ADULT AND CHILD CORE SET SPECIFICATIONS

- None.

XVII. STANDARD QIP MODIFICATIONS FROM SOURCE SPECIFICATIONS

A. ALL SPECIFICATIONS

- Priority Measures are noted by an asterisk in front of the title. Refer to **Section V.C. Priority Measure Reporting** for directions on reporting Priority Measures by QIP entity characteristics.
- Removed all references to Commercial and/or Medicare product lines, except the Medicare Special Needs Plan (SNP) and “living long-term in an institution” exclusion.
- Included a reference to **Section XIV.B. Stratification of Reported Data by Medi-Cal Health Plan**.
- Removed copyright language because it is included in **Section XVIII. QIP Measure Copyright Table** of the *General Guidelines for QIP Data Collection and Reporting.*
- Replaced references to “Continuous Enrollment” with “Continuous Assignment to QIP Entity” (HEDIS and Core Set).
- Added QIP target population language for all measures, including guidance on persons with “other health coverage” (refer to **Section X. QIP Target Populations** for target population details).

B. HEDIS SPECIFICATIONS

- Replaced all references to “organization” with “QIP entity.”
- Removed “*Data Elements for Reporting*” section describing requirements for plans reporting to NCQA because it is not applicable to QIP.
- Removed “*Rules for Allowable Adjustments*” section describing rules for permissible modifications to the HEDIS measure.
- Removed the Benefits line, because it does not apply to QIP reporting.
- Removed language regarding reducing sample size from HEDIS hybrid measures.

C. MIPS ECQM SPECIFICATIONS

- Replaced references to “eligible clinicians” with “QIP entities.”
- Throughout, removed references to “Payer,” “Race,” “Ethnicity,” and “Sex,” because supplemental data elements are not used for reporting in QIP.
- Removed the eCQM title row because it is not relevant to QIP reporting.
- Removed *Transmission Format* section because it is not relevant to QIP reporting.
- Removed *References* section from the specification and added a note to refer to the source specification for a full list of references.
- Removed *Supplemental Data Elements* from the measure header because they are not used for reporting in QIP.

D. MIPS CQM SPECIFICATIONS

- Replaced references to “eligible clinicians” with “QIP entities.”
- Replaced “submitted/submitting” with “reporting/reported” throughout the measure.
- Removed the following statements from the *Measure Reporting* section because they do not apply to QIP:
    - “Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries.”
    - “The quality-data codes listed do not need to be reported by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be reported for those registries that utilize claims data.”
    - “For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.”
- Removed measurement year reference from the measure flow charts and narratives.

E. CMS ADULT AND CHILD CORE SET SPECIFICATIONS

- Replaced references to “states” with “QIP entities.”
- Removed the Benefits line because it does not apply to QIP reporting.

F. OTHER SPECIFICATIONS

- None.

XVIII. QIP MEASURE COPYRIGHT TABLE

Refer to the list of measures and associated Measure ID in the document's navigation pane and table of contents.

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Table 13: QIP Measure Copyright Table

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