

Quality Incentive Pool (QIP) Program

Calendar Year 2026 (CY2026)

QIP Program Policies

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. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording or any information storage and retrieval system, except for the purposes of reporting quality data for the QIP program or for internal quality improvement activities.



Table Of Contents

- Quality Incentive Pool (QIP) Program..... 1
 - Table Of Contents 2
- QIP Program Policies 3
 - I. Background4
 - A. Navigating The CY2026 Manual..... 4
 - II. About The QIP Program Policies Section5
 - A.CY2026 Document Control Log: QIP Program Policies.....5
 - III. Reporting Calendar5
 - A. CY2026 Reporting Dates 6
 - IV. QIP Measures.....6
 - A. Measure Specification Types 6
 - V. Compliance Requirements7
 - A. Minimum Data Reporting Requirements..... 7
 - B. Minimum Narrative Reporting Requirements..... 9
 - C. Priority Measure Reporting..... 11
 - D. DMPH Community Partner Eligible Measures..... 11
 - E. Multiple Hospital QIP Entities 12
 - F. QIP Data Integrity Policy 13
 - G. Updating Enrollment Information..... 17
 - H. Updating Beneficiary Contact Information Via County Social Services 17
 - I. Health Plan Data..... 17
 - VI. Payment19
 - A. Pay-For-Performance 19
 - B. Benchmarks 19
 - C. Trending Breaks..... 20
 - D. Target Setting 20
 - E. Achievement Values..... 21
 - F. Calculating Payments..... 25

QIP PROGRAM POLICIES

I. BACKGROUND

The Department of Health Care Services (DHCS) has implemented a Medi-Cal managed care Designated Public Hospital (DPH) Quality Incentive Pool (QIP); starting in CY2021, formerly known as Program Year 4 (PY4), the program includes District and Municipal Public Hospitals (DMPHs).

The Department directs Medi-Cal managed care plans (MCPs) to make quality incentive payments to QIP entities based on their performance on quality measures specified in the QIP Reporting Manual. The QIP advances the State's Quality Strategy goal of enhancing the quality of DHCS programs by supporting DPH systems and DMPHs (hereafter "QIP entities") in delivering effective, efficient, affordable care. The QIP also promotes access to care and value-based payment arrangements, increasing funding tied to quality outcomes while further aligning state, MCP, and hospital system goals. The program integrates historical supplemental payments, in compliance with the managed care final rule [42 Code of Federal Regulations (CFR) 438.6(c)], by linking payments to utilization and delivery of services under MCP contracts.

Prior to implementing the QIP CY2026 measures, QIP entities should review the entire QIP Reporting Manual, including the *QIP Program Policies* section, the *General Guidelines for QIP Data Collection and Reporting*, and all applicable measure specifications and appendices, as well as all relevant Inquiries and Responses to CY2026 measures from NCQA's Policy Clarification Support Report (aka "PCS Report") posted on eQIP. The *QIP Program Policies* and the *General Guidelines for QIP Data Collection and Reporting* apply to all QIP measures.

A memorandum will be released in Spring 2026, outlining all corrections, policy changes, and clarifications from the MY 2026 HEDIS Technical Update and the Specifications Manual for Joint Commission National Quality Measures Version 2026B that apply to the QIP program; entities are responsible for applying all updates to the QIP CY2026 Reporting Manual, as applicable.

A. NAVIGATING THE CY2026 MANUAL

All key headings are available as bookmarks in the CY2026 Manual. Use the PDF Navigation Pane in the left-hand column of the manual to view and use them to navigate through the document.

Measures in the Measure Category Summary Tables are also linked to their location in the CY2026 Manual.

II. ABOUT THE QIP PROGRAM POLICIES SECTION

The *QIP Program Policies* section is a user-friendly resource for QIP managers and reporting leads. It provides information about participating in the QIP program, including compliance requirements and payment information. Citations from DHCS policy documents not included in the *Program Policies* are in quotes, with the relevant policy document listed as the source. Text that is not in quotes paraphrases cited documents or is additional DHCS guidance.

A. CY2026 DOCUMENT CONTROL LOG: QIP PROGRAM POLICIES

Modifications from CY2025 Manual

- Updated all dates and references to PYs. For this current publication, Program Year (PY) is updated to Calendar Year (CY) for all former, current, and future PYs.
- Removed all references to CY2025 (formerly PY8).
- Updated measure ranges in Table 1 in section V. A. Minimum Data Reporting Requirements.
- Updated report level questions and notes in section V. B. Minimum Narrative Reporting Requirements.
- Added note about reasons to select “not reporting” to section V. C. Priority Measure Reporting.
- Removed Q-AMR and Q-CMS147 from and added Q-LSC-E to Table 2 in section V. D. DMPH Community Partner Eligible Measures.
- Updated section VI. E. Achievement Values to include more gradient values for calculating achievement values (AV).
- Removed DRR-E from and added Q-BCS-E and Q-DSF-E to the measure and sub-rate exceptions list in section VI. E. Achievement Values.
- Removed section VI. Over-Performance, because over-performance is no longer applicable due to an expansion of AV scoring.

III. REPORTING CALENDAR

Because QIP payments are factored into Medi-Cal managed care rates and represent incentives for the quality of services provided during a specific rating period (calendar year [January–December], in this case), the QIP measurement year will adhere to the approved rate year between plans and the State.

For CY2026, be aware of the following annual report measurement period, annual report due date, and estimated timing of payments to each QIP entity by its MCP:

- CY2026 Annual Report Measurement Period: January 1–December 31, 2026.
- Annual Report due: Tuesday, June 15, 2027.
- “Better of” Measures due: Tuesday, June 22, 2027.
- For eligible QIP entities, DHCS will release an interim payment in September 2027 (for more information, refer to [Section VI. F. Calculating Payments](#)).
- Estimated date of QIP payment to each QIP entity by its MCP: No later than Friday, June 30, 2028.

A. CY2026 REPORTING DATES

All QIP CY2026 data are due by **11:59 p.m. on Tuesday, June 15, 2027**, for the Annual Report and **Tuesday, June 22, 2027**, for the “better of” measures. **No extensions will be granted.** The QIP Reporting Application will automatically lock all data submitted by these deadlines and will not allow further data entry or modifications. QIP entities must follow **ALL** guidance for **QIP** issued by DHCS, including, but not limited to, emails, QIP Policy Letters (QPLs), and this QIP Reporting Manual. Entities must also follow all measure guidance provided by the measure stewards in the PCS Report, unless otherwise directed by DHCS. **It is the sole responsibility of the QIP entity to ensure that it meets ALL QIP requirements and follows ALL DHCS guidance.**

Note: Technical assistance from DHCS will be available until 5 p.m. Tuesday, June 15, 2027, for Annual Reporting and 5 p.m. on Tuesday, June 22, 2027, for the “better of” measures. Contact DHCS as soon as possible with questions or concerns, to ensure that you receive the necessary support.

IV. QIP MEASURES

There are 58 measures across all measure categories in QIP CY2026. (Refer to the table of contents and the navigation pane.) Each measure has a corresponding measure ID and measure name. Priority Measures have an asterisk (*) in front of the measure title in the Table of Contents and the measure specifications. Outside the Priority Measures, there are three informational measures, and all other measures are elective.¹

A. MEASURE SPECIFICATION TYPES

There are several types of QIP measure specifications, including, but not limited to, HEDIS®,² MIPS CQM, eCQM, and CMS Medicaid Adult and Child Core Set (hereafter “CMS Adult and Child Core Set”).

For more information on:

- eCQMs, refer to the [Guide for Reading eCQMs](#) (PDF) and the [eCQI Resource Center’s Eligible Professional / Eligible Clinical eCQMs](#) page.
- MIPS CQMs, download the [2025 Clinical Quality Measure Specifications and Supporting Documents](#) and view the PDF titled “**2025 MIPS Clinical Quality Measure Guide.**”

¹For CY2026, Q-FUAH: Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits Within 7 Days Post Hospital Discharge, Q-ECM: Number of Individuals Enrolled in ECM, and Q-COMS: Number of and Percentage of Eligible Individuals Receiving Community Supports, and Number of Unique Community Supports Received by Individuals are required to be reported as informational-only measures.

²HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Guidance on HEDIS, the CMS Adult and Child Core Set, and other specification types can be found in the corresponding source specification manuals, as applicable.

IMPORTANT CLARIFICATION:

Outside QIP, not all specifications for measures of the same name are completely clinically aligned. As such, QIP entities must only use the specifications listed in this QIP Reporting Manual. As new specification types (e.g., eCQM) become available, they may be incorporated into the QIP Reporting Manual if they align appropriately with existing QIP measures.

V. COMPLIANCE REQUIREMENTS

A. MINIMUM DATA REPORTING REQUIREMENTS

Pursuant to the QIP CY2026 Preprint, each DPH system must annually report at least 40 measures from the list of DHCS-approved performance measures (20 measures are designated as Priority Performance Measures).

Each DMPH entity must annually report on at least its minimum number of measures committed. The DMPH’s specific minimum commitment number must be selected within the range specified by the tiers in [Table 1](#), determined by annual DMPH Medi-Cal Revenue. For DMPHs that offer the relevant clinical service lines, at least 50 percent of the minimum number of committed measures must be reported from the Priority Measure sub-set. DMPHs in Tier 2 that have “rural hospital” designation, defined by CA Health & Safety Code section 124840, have the option to move to Tier 1.

Table 1: DMPH QIP Tiers

DMPH QIP Tier	Measure Range Minimum	Measure Range Maximum	Sum of Net Medi-Cal Revenue*
1	1	15	<\$30 million
2	7	20	≥\$30 million

*<https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables/resource/e6a7cc46-836f-4437-8ad1-e485d6ea0514>

DMPHs will select a minimum number of measures to report for CY2026 in a measure commitment survey DHCS will conduct in the first quarter of CY2026 (60 calendar days after the release of the CY2026 Reporting Manual). This minimum measure commitment number will apply to CY2026.

If a QIP entity does not report on at least the minimum number of measures required, the entity will not receive **ANY** QIP payment for that CY.

The following policies apply to measures impacted by denominators of <30:

- 1) A QIP entity may use a measure with a denominator of <30 to fulfill its minimum number of required measures for QIP reporting.
- 2) A denominator of ≥ 30 for two consecutive CYs is required for a QIP measure to earn a nonzero achievement value (AV), as determined by performance, and be eligible for payment. This policy also applies to Elective Measures with identical denominator sub-rates, such as measure **Q-WCC: Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents**. A QIP entity will earn an AV of zero, and will not earn funding for this type of sub-rate that does not meet this requirement. The measure's total AV will be an average of the individual sub-rate AVs. An individual sub-rate that does not meet this requirement will decrease the total AV and funding for the measure.
- 3) A measure containing accountable sub-rates with non-identical denominators will have the total AV exclude any sub-rate containing a denominator of <30 for either the current or baseline CY, if the conditions described in a) or b) are present.
 - a) The measure's sub-rate denominator population is limited by patient demographic characteristics such as age, race, or ethnicity (i.e., for CY2026, Q-PND-E, Q-PDS-E, Q-W30, and Q-GSD). Additional requirements apply if both sub-rates for Q-GSD have denominators <30 but the total Q-GSD denominator is >30. Refer to Q-GSD for complete information.
 - b) The measure's sub-rate denominator population is limited by the prevalence of a particular condition or risk factor, and/or patient behavior, such as tobacco use (i.e., for CY2026, Q-CMS138).

If all sub-rates and the overall rate in a Priority Measure contain denominators <30 for either the current CY or prior CYs, an AV of zero applies to the measure. The entity should consider a replacement Priority Measure (for DMPHs) or Elective Measure (for DPHs or for DMPHs that have exhausted the Priority Measure list), in accordance with [Section V. C. Priority Measure Reporting](#).

Furthermore, each reported measure (except **Q-HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems**, **Q-CDI: Reduction in Hospital Acquired Clostridium Difficile Infections** and **Q-SSI: Surgical Site Infection (SSI)**) must include data from at least one person enrolled in Medi-Cal managed care during the reporting CY in order for payment to be made for the measure for that CY. For reported sub-rated measures, at least one sub-rate must include data from at least one person enrolled in Medi-Cal managed care. A QIP entity will earn an AV of zero, and will not receive payment for a reported measure in which data do not include at least one Medi-Cal managed care life. However, the measure may still be used to fulfill the required number of measures for a QIP entity's reporting.

Exceptions to the Minimum Reporting Requirements:

- a) The minimum of 30 individuals or cases and the minimum Medi-Cal managed care lives requirement do not apply to the informational-only measure or sub-rates listed in [Section VI. E. Achievement Values: Measure and Sub-Rate Exceptions](#), or to **Q-CDI: Reduction in Hospital Acquired Clostridium Difficile Infections** and **Q-SSI: Surgical Site Infection (SSI)**.
- b) The minimum number of individuals or cases is higher for **Q-PCR: Plan All-Cause Readmissions**. To earn a nonzero AV, as determined by performance, on Q-PCR, the entity must have a minimum of 150 Index Discharges for the CY.
- c) The minimum number of surveys for the **Q-HCAHPS** measure reporting is 300 surveys per QIP entity facility per CY. For example, if the entity has three facilities and only one meets reporting requirements, then only that facility will be included when the entity reports the measure.

Refer to **Section X. QIP Target Populations** for the definition of “enrolled in Medi-Cal managed care.”

B. MINIMUM NARRATIVE REPORTING REQUIREMENTS

QIP entities must report narratives in QIP reports, based on the following prompts.

Report Level:

Question 1: List each MCP contract, effective date, number of assigned lives, as defined below, and how each contract meets the minimum criteria outlined in the DHCS memo, [Hospital Directed Payment Definition for SFY 2017-18 and SFY 2018-19](#) dated 10/05/18. For each MCP contract, report the number of assigned lives with 12 months of continuous QIP entity assignment (with allowance for a 45-day gap) for the period of January 1, 2026, through December 31, 2026. Managed care lives who did not have 12 months of continuous assignment to the QIP entity should not be included, but lives continuously assigned to the QIP entity who switch MCPs may be included if this is indicated in the narrative. If an MCP does not provide the QIP entity with assigned lives data in time for QIP reporting, state it, and the reason, in the narrative at the time of report submission.

Question 2: If data were received by April 30, 2027*, state the frequency and timing (e.g., monthly, by a specific date) the QIP entity received the following data from its MCP(s)**:

- a) Eligibility (Enrollment and Assigned Lives).
- b) Clinical Service (e.g., Encounter, Claim, Fee for Service, other Supplemental Data).

*If data were received after the April 30, 2027 deadline, but were not used for reporting, please state it in the narrative.

**Indicate N/A if the entity is not reporting on assigned lives measures.

Measure Level:

Question 1:

- a) Describe data sources that inform calculation for each measure. Provide a high-level description of data sources that are integrated in the QIP entity's calculation and reporting of performance measures. List all data sources used to identify the specified denominator population, as well as numerator compliance and any exclusions, for each performance measure. Data sources include internal source data (e.g., EMR, eligibility data) and external source data (e.g., Meditech lab, California Immunization Registry (CAIR), MCP claims, Care Everywhere).
- b) Describe how measures were calculated (e.g., using source code programming, manual workflow and data extraction, mixed methodology). Provide a high-level description of the methodology (e.g., source code programming or manual workflow and data extraction, mixed methodology) used to calculate the denominator and numerator for reported measures.

Note:

- If using sampling, include information on the number of individuals in the Total Population before sampling.
- If reporting numerator zero and/or the denominator is <30 (including zero), explain why.
- Enter the measure-specific information requested in the manual and QPL(s) (e.g., Q-PCR data elements, Q-SSI prior year's predicted infection count, and measures with target populations that have two criteria [Q-COL-E and Q-CMS314] step results [criteria 1, criteria 2, and de-duplication of criteria 1 and 2]).
- For the Q-FUA, Q-FUI, and Q-FUM measures, indicate if ALL associated-MCPs' data are included to evaluate completeness and eligibility for pay-for-performance.
- For "better-of" measures (Q-FUA, Q-FUI, Q-FUM, Q-CCS, Q-CIS, Q-CHL, Q-IMA), provide the data (numerator, denominator, and rate) from the data source that is not reported for pay-for-performance (either QIP entity produced rate or MCP produced rate).

Question 2:

Describe the quality improvement efforts for this measure. Provide details such as new policies and procedures, outreach efforts, and/or implementation of workflows, programs, and collaboratives. Describe any challenges to improvements on this measure, and how these challenges will be addressed. Copying and pasting the same information from the prior CY narrative is not sufficient for the current CY.

C. PRIORITY MEASURE REPORTING

The Priority Measure sub-set represents measures that are high priority to the State and to Medi-Cal MCPs. The sub-set comprises measures from the [Managed Care Accountability Sets](#) (MCAS), for which MCPs have Minimum Performance Levels, plus measures representing conditions with high priority, high prevalence, or high mortality in California. Priority Measures are identified by an asterisk (*) before the measure title. QIP entities' reporting requirements for these measures are based on entity type and characteristics, as follows:

- *DPH systems*: Required to report all Priority Measures with a denominator ≥ 30 . QIP entities use the QIP Reporting Application to demonstrate that they cannot achieve a denominator ≥ 30 for a Priority Measure, or do not provide the relevant clinical services. DPHs that cannot report a Priority Measure due to either of these circumstances must report one or more additional Elective Measures, as needed, to report a total of 40 measures for the CY.
- *DMPH entities*: Required to report at least 50 percent of the required minimum committed measures from the Priority Measure sub-set. If the DMPH cannot achieve a denominator ≥ 30 for any required Priority Measure, or does not provide the relevant clinical service (e.g., prenatal or postpartum care), it must choose another Priority Measure(s) on which to report. If no other Priority Measure is applicable, the DMPH may substitute a measure from the Elective Measure list. **A DMPH may only select “Not Reporting Reason: Not required (DMPH Only)” if it already met and satisfied its required number of Priority Measures to report.**

***Note:** Not meeting the benchmark and not tracking the measure are not valid reasons to select “Not Reporting.” If an entity has an ED, then the Q-FUA and Q-FUM measures should still be considered for reporting when trying to meet the number of Priority Measures.*

D. DMPH COMMUNITY PARTNER ELIGIBLE MEASURES

DHCS may approve a DMPH to use contracted community partner data for specified allowable measures for the QIP program. As part of the QIP program, participating DMPHs and their approved contracted community partners must engage in shared quality improvement efforts to improve the coordination and quality of care, as well as health outcomes, for their shared Medi-Cal beneficiaries. To participate, the DMPH must clearly demonstrate its role in these efforts. Additional guidance for the application and approval process will be provided in a forthcoming QPL.

DMPHs approved to include data from community partner patients in their QIP reports must apply a consistent, identical method for including all eligible contracted community partner patient data in the allowable QIP measures on which they select to report. All DMPHs with approval **must** include all patients from the contracted community partner who meet measure denominator criteria **and** had at least one encounter with the DMPH during the measurement period.

Table 2: QIP Measures Allowable for Community Partner Data

QIP Measures Allowable for Community Partner Data
Q-BCS-E: *Breast Cancer Screening (BCS-E)
Q-GSD: *Glycemic Status Assessment for Patients with Diabetes (GSD)
Q-CIS-E: *Childhood Immunization Status
Q-COL-E: *Colorectal Cancer Screening
Q-COB: Concurrent Use of Opioids and Benzodiazepines (COB-AD)
Q-LSC-E: *Lead Screening in Children (LSC-E)
Q-FUA: *Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
Q-FUAH: Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits Within 7 Days Post Hospital Discharge
Q-FUI: Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)
Q-FUM: *Follow-Up After Emergency Department Visit for Mental Illness (FUM)
Q-POD: Pharmacotherapy for Opioid Use Disorder (POD)
Q-CMS135: Heart Failure (HF): ACE/ARB/ARNI Therapy for LVSD
Q-IHE1: *Improving Health Equity (Q-IHE-1)** ¹
Q-IHE2: Improving Health Equity (Q-IHE-2)** ¹
Q-IMA-E: *Immunization for Adolescents
Q-PCE: Pharmacotherapy Management of COPD Exacerbation (PCE)
Q-PND-E: Prenatal Depression Screening and Follow-Up (PND-E)
Q-PDS-E: Postpartum Depression Screening and Follow-Up (PDS-E)
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-PRS-E: Prenatal Immunization Status (PRS-E)
Q-TRC: Transitions of Care (TRC)
Q-OHD: Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)

*Priority Measures.

**Q-IHE measures are allowed for community partner data only if the entity engages in improving equity for Q-BCS-E, Q-PPC-Pre, and Q-PPC-Pst.

¹QIP entities must report on the parent measure if reporting on a Q-IHE measure.

E. MULTIPLE HOSPITAL QIP ENTITIES

QIP entities with multiple hospitals operating under common ownership will be considered a single entity for QIP reporting, and must report on QIP measures accordingly.

F. QIP DATA INTEGRITY POLICY

This QIP Data Integrity Policy (added from [QPL 24-002 Data Integrity Policy](#)) provides guidance on collecting, maintaining, and sharing data as a vehicle for maximizing health care value through the QIP program.

In accordance with [Welfare & Institutions Code §14197.4\(c\)\(1\)\(B\)](#), this section sets forth data reporting requirements QIP entities must follow throughout the duration of the QIP program.

For the purposes of this section, data integrity is defined as the quality, consistency, reliability, accuracy, and completeness of data collected and reported under the QIP program.

QIP Entity Responsibilities

Each QIP entity must:

- a) Review this policy.
- b) Ensure that their data handling practices comply with the requirements in this section.

Scope

The QIP Data Integrity Policy applies to all entities participating in the QIP program. This policy constitutes a minimum viable standard for maintaining data quality and integrity under the QIP program. This section is not intended to interfere with any legal, privacy, regulatory, and/or security-related procedures and requirements that permit entities to conduct their regular business.

Data Integrity Requirements

As a requirement for participating in the QIP program, by submitting QIP data, QIP entities agree and attest that they comply with the following QIP Data Integrity Policy requirements:

- The QIP entity's leadership, management, and all levels of staff, must make a good-faith effort to manage risks that might undermine the data integrity of the QIP program.
- QIP entities must have adequate documentation governing the rate production process. Except for MCP-reported rates, QIP entities must be able to show access to source data and show the detailed process to produce rates. When requested, QIP entities must provide DHCS with supporting documentation of the change and its impact on the numerator, denominator, and rate for DHCS review and determination. This could include summary of the identified error, the correction applied, screenshots of the code change and/or revised documentation (correction), count differences before/after, the rationale for the correction, and a plan to mitigate future discrepancy.

- QIP entities must facilitate data integrity through self-governance; they have the lead responsibility for preventing, deterring, identifying, and rectifying data integrity issues in their respective programs.
- QIP entities must host and maintain policies and procedures defining the data governance process, which outlines how the entity ensures data integrity and prevents data integrity issues.
- QIP entities must ensure that QIP data meet the following standards:
 - Attributable— establishing who performed an action, and when.
 - Legible— recorded permanently in a durable medium, readable by others, with traceable changes.
 - Contemporaneous— with activities recorded when they occur (when an activity is performed, or information is obtained).
 - Accurate— reflecting the true information.
- For the purpose of data corrections in the QIP Reporting Application, QIP entities must distinguish between current CY data, prior CY data, measures in scope of audit, and measures not in scope of audit:
 - For measures in scope of audit, current CY quantitative data may be corrected in the QIP Reporting Application if the auditor concurs with the corrections and validates the data during the audit period. Current CY qualitative (e.g., narrative) data may also be corrected in the QIP Reporting Application, at the discretion of DHCS, during the review period.
 - For measures not in scope of audit, current CY quantitative and qualitative data may be corrected in the QIP Reporting Application, at the sole discretion of DHCS, during the review period. The QIP entity must provide written justification and supporting documentation (e.g., summary of identified error, correction applied, screenshots of the code change and/or revised documentation [correction], count differences before/after, rationale for the correction, and plan to mitigate future discrepancy) to DHCS for review and approval.
 - For prior CY data (baseline data reported in a previous CY) for all measures, the reporting QIP entity may not make any data corrections to the affected measure in the QIP Reporting Application. However, for awareness and tracking purposes, the QIP entity must:
 - Inform the QIP Liaison and/or assigned auditor (depending on the measure). *Example: For Q-SSI and Q-CDI measures, the QIP entity must contact the QIP Liaison.*
 - Report the corrected data, issues that required corrections, their impact on the reported rate, and any action plans taken to mitigate them in the current CY measure's narrative. Refer to *Data Modification* for limitations on calculating targets (e.g., for gap closure).

- QIP entities must retain applicable supporting documentation for 10 years after submitting CY reports, and must make such documentation available for an audit conducted by external parties. Retention of documentation includes maintaining all patient-level data used to create submitted QIP reports.
- QIP entities must document and retain records of all incentive payment amounts earned under QIP, as well as clinical and quality improvement data for QIP reports for 10 years after submitting CY reports.
- Until DHCS sends an official notification that CY reporting is officially approved and closed, QIP entities must retain copies of files and databases used for performance measure reporting, in the event results need to be reproduced and/or recalculated based on identified need for corrections. QIP entities must ensure no new data, post submission period, are introduced into recalculated and/or reproduced rates.
- QIP entities must report to DHCS and the auditor, within 10 business days of discovery, any breach of these QIP data integrity requirements that results in discrepancies from submitted QIP quantitative or qualitative reports.
 - QIP entities must report the breach by emailing their QIP Liaison (and auditor, if an audit is ongoing and the measure is under audit) with a summary of the discovery that includes the following information:
 - Date of discovery of the data breach.
 - How the discrepancy was discovered.
 - The affected measure(s), including a detailed measure list and a description of the findings.
 - How the error(s) were corrected.
 - The mitigation process implemented to prevent future incidents.

As requested and directed by DHCS, the QIP entity must participate in further communication with DHCS.

PCS Responses

As QIP entities, auditors, and DHCS evaluate measures and related data, the most recent NCQA Policy Clarification Support (PCS) system response will supersede prior PCS responses (when there are conflicts or discrepancies in PCS). PCS responses will only be included in the audit process if a PCS question is submitted 30 calendar days prior to the QIP CY reporting submission deadline. After that date, no additional PCS responses may be considered when evaluating or auditing measures and related data, and entities and auditors should use only previously released measure specifications, PCS responses (recognizing that those submitted by the deadline will come back after the deadline), prior QIP policies, and prior DHCS communications. Exceptions to the scope of audit must be reviewed and approved by DHCS. Additionally, any exception approved by DHCS must be implemented within the time frame decided by DHCS. Refer to *Dispute Resolution* if these documents result in a dispute between parties.

Data Modification

QIP entities must submit complete and accurate data to DHCS by the applicable reporting deadline, in accordance with all requirements set forth in this section. QIP entities may not request data modifications after the reporting deadline unless they obtain prior approval from DHCS and/or the DHCS external auditor. DHCS and/or the DHCS external auditor evaluate reports for validity and accuracy. DHCS, at its sole discretion, may request data corrections if data fail to meet necessary requirements. Submitted data will be considered final, and all QIP payments, future target rates, and publicly reported data will be based on the final data. For example, if a data integrity issue is recognized in a future CY, and the issue would have changed the measure rate, no changes to the prior finalized rates will be allowed.

The prohibition on data modifications after the reporting deadline does not relieve QIP entities of their duty to report any breach of QIP data integrity requirements, nor does it prohibit DHCS and/or external oversight entities from evaluating the data submitted for data errors resulting from data breaches, fraud, willful negligence, or unintentional errors.

DHCS may grant an entity a reporting deadline extension if there is an unexpected significant impact on data systems out of the QIP entity's control, such as incapacitation of data systems or natural disasters affecting operations. If system incapacitation events affect reporting to the point of a delay beyond the reporting deadline, the QIP entity must notify DHCS in writing as soon as it is aware of the delay.

Dispute Resolution

DHCS and external auditors will partner with QIP entities to make a best effort to resolve disputes prior to escalation. If significant audit disputes arise between auditor and entity, the QIP entity should immediately notify DHCS, via an email to its QIP Liaison, and provide the following information:

- The exact issue encountered.
- Specific measure(s) affected and disputed.
- Auditor concerns with the metric specification interpretation, timeline, code review, and/or other audit tasks.

For measure-related issues not addressed in the measure specifications, DHCS and the external auditor will determine if a PCS question should be submitted. DHCS, auditors, and entities should accept and follow the most recent PCS response.

DHCS has the sole authority to resolve disputes when current QIP policies, measure specifications, PCS responses, or other formal QIP documents do not give clear guidance.

G. UPDATING ENROLLMENT INFORMATION

If the QIP entity determines, through direct communication with a beneficiary (or the beneficiary's authorized representative), that the beneficiary's assignment is incorrect, the QIP entity should exclude the patient from the affected measure(s) if *BOTH* the following are true:

- 1) The QIP entity has confirmed with the original MCP that the beneficiary's assignment is no longer correct.
- 2) Correcting this assignment information results in the beneficiary no longer meeting continuous assignment criteria of the affected QIP measure(s).
 - The QIP entity should retain documentation that substantiates the MCP's confirmation that the beneficiary does not meet continuous assignment criteria.

H. UPDATING BENEFICIARY CONTACT INFORMATION VIA COUNTY SOCIAL SERVICES

If a QIP entity is unable to contact a Medi-Cal beneficiary using the contact information provided by the MCP in the monthly eligibility file (i.e., returned QIP entity mail to that beneficiary), the entity may choose to report this to the MCP and/or the County Social Services Eligibility Department. If the Social Services Eligibility Department provides confirmation that the patient was disenrolled from Medi-Cal managed care, and disenrollment means the patient no longer meets continuous assignment criteria for the measurement period, the QIP entity should remove the patient from the denominator of the affected measure(s).

If a QIP entity determines, through direct communication with the beneficiary (or the beneficiary's authorized representative), that the beneficiary's contact information provided by the MCP in the monthly eligibility file is no longer correct, the QIP entity may choose to report changes or updates to the MCP and/or the County Social Services Eligibility Department. When updated beneficiary contact information is provided to the county, the county is responsible for following regulations in accordance with [All County Welfare Directors Letter No. 15-30, dated September 22, 2015](#).

If the change or update results in disenrollment of the beneficiary from Medi-Cal managed care, and the disenrollment occurs during the measurement period, the patient no longer meets continuous assignment criteria for the measurement period and the QIP entity should remove the patient from the denominator of the affected measure(s).

I. HEALTH PLAN DATA

The QIP program allows participating DPH and DMPH systems to earn performance-based quality incentive payments, as directed by DHCS, from MCPs with which they contract as Network Providers. QIP entities must submit reports directly to DHCS with any information necessary for DHCS to evaluate achievement of applicable performance measures and calculate the amount of QIP-directed payments earned.

MCPs' contracts with DHCS (refer to [Medi-Cal Managed Care Boilerplate Contracts](#)) require compliance with the terms of each directed payment program approved by CMS under 42 CFR 438.6(c), as specified by DHCS through All Plan Letters (APLs) or other technical guidance. All Medi-Cal MCPs are required to provide QIP entities with the Minimum Necessary Dataset for QIP reporting.

MCPs must assist QIP entities, including DMPHs seeking information related to DHCS-approved contracted DMPH community partners, in collecting information necessary to complete QIP quality improvement efforts and reporting obligations for all years in which the QIP program is in effect. This includes providing QIP entities with the Minimum Necessary Data outlined by DHCS, which may include, but is not limited to, Medi-Cal member eligibility, lab tests and results (to the extent allowed by applicable laws and regulations), pharmaceutical and non-pharmaceutical claims data, and data for persons with other health coverage, which may include dually eligible enrollees, as defined in state and federal law.

DHCS will regularly notify MCPs, via guidance on the [DHCS QIP webpage](#), of the specific DMPH community partners with which data must be shared, the specific data elements that must be shared with QIP entities and community partners, and any associated deadlines for the data. DHCS will email MCP Medical Directors when the required data elements are posted on the DHCS QIP webpage.

MCP data must be received by the QIP entity by April 30, following the end of the CY, in order to be included in the QIP entity's report (except for MCP-reported numerators, denominators, and rates for measures that are either MCP-reported or QIP entity-reported rates.³ DHCS will release expectations on the timeline for MCP data at a later date). MCP data received by the QIP entity after April 30, following the end of the CY, are not required to be included by the QIP entity in its QIP report, but may be included at the QIP entity's discretion. In the Report-Level Question 2 in the QIP Reporting Application, QIP entities provide the status of receipt and inclusion of MCP data in calculations of their performance data.

³ For CY2026, Q-FUA, Q-FUI, Q-FUM, Q-CCS-E, Q-CHL, Q-IMA-E, Q-CIS-E, Q-W30, Q-PPC-Pst, Q-PPC-Pre, Q-LSC-E, and Q-WCV are designated for "better of" MCP reporting.

VI. PAYMENT

A. PAY-FOR-PERFORMANCE

Although most measures in this manual are reported on a pay-for-performance basis for CY2026, several have sub-strata rates that are reported on an informational basis (refer to [Section VI. E. Achievement Values–Measure and Sub-Rate Exceptions](#)). For CY2026, **Q-ECM: Number of Individuals Enrolled in ECM**, **Q-COMS: Number of and Percentage of Eligible Individuals Receiving Community Supports**, **Number of Unique Community Supports Received by Individuals**, and **Q-FUAH: Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits Within 7 Days Post Hospital Discharge** are reported on an informational basis.

A QIP entity choosing to report on a performance measure for CY2026 must also report data for CY 2025 (CY2026 baseline), if not previously reported in CY2025, according to specifications from the CY2026 Manual. A QIP entity will receive payment for achieving targets only; no payment will be given for reporting historical performance. **The QIP Reporting Application will not allow QIP entities to report CY2026 data until the QIP entity reports CY 2025 data.** Stratification by MCP is not required for historical data.

Pay-for-performance: The measure's AV will be determined by the progress made toward achieving the measure performance target, per [Table 4: Measure Performance Achievement Values](#).

B. BENCHMARKS

DHCS-approved QIP CY2026 minimum, median, and high performance levels (performance benchmarks) are determined for each QIP measure using national benchmarks, where available. DHCS prioritized the use of Medicaid 25th, 50th, and 90th percentile benchmarks as the minimum, median, and high performance benchmarks, where available. For Q-FUA, Q-FUI, and Q-FUM in CY2026, the Medicaid 10th, 25th, and 50th percentile benchmarks will be used as the minimum, median, and high performance benchmarks.

For QIP measures without available Medicaid benchmarks, DHCS will establish appropriate minimum, median, and high performance benchmarks by using processes and criteria approved for identifying benchmarks for non-Medicaid benchmarked measures in the QIP program. These processes take into account all available performance data on a measure (national, state, or QIP entity-specific data), as well as known variances between the populations measured by the available performance data and the Medi-Cal managed care populations measured by QIP.

DHCS will adjust benchmarks for each QIP CY according to updates made by the national measure stewards. DHCS may also update non-Medicaid benchmarked measures annually, as appropriate, based on the most recently available State or QIP entity data. Benchmarks for CY2026 are sent via email through the [QIP Mailbox](#).

Benchmarking for CY2026

The available benchmarks for the majority of QIP CY2026 measures use data from Measurement Year (MY) 2024 (a few use data from MY 2023), as described below.

At the start of CY2026, DHCS will release CY2026 benchmarks generated from MY 2024 (or MY 2023) data.

C. TRENDING BREAKS

DHCS will issue a QPL to inform QIP entities of the correct procedure in the event of a measure trending break. This type of reporting results from a change in a measure specification between two CYs that usually requires modification to the following CY's target rate. When a trending break is identified for any measure QIP entities reported in CY2025, entities must also re-report baseline (CY2025) performance rates using CY2026 specifications. Reporting two versions of the data, as per the applicable DHCS trending break policy, will account for trending breaks and enable comparison of achievement rates.

D. TARGET SETTING

Individual QIP entity performance targets (except Q-PCR, Q-CDI, and Q-SSI; refer to [Ratio Based Risk Adjusted Measures](#) for setting targets for those measures) will be calculated according to the following Gap Closure methodology, with the QIP entity's performance rate and final target rounded to the same number of decimal places as the measure's benchmark.

The "gap" is defined as the difference between the QIP entity's end of prior CY performance and the current CY's high performance benchmark. The target setting methodology for QIP is a 10 percent gap closure, as described below.

QIP entities must perform at or above the established minimum performance benchmark described in [Table 4: Measure Performance Achievement Values](#) in [Section VI. Payment](#). QIP entities with performance at or above the high performance benchmark for a measure will be considered to be at 100 percent of their quality goal, and will be required to achieve performance that maintains or exceeds the measure's high performance benchmark for the subsequent CY.

The following is an example of 10 percent Gap Closure Target Setting Methodology for CY2026 QIP measures:

- *Improvement*: Performance \geq 25th percentile and $<$ 90th percentile
 - 10% gap closure between CY 2025 performance and CY 2026 high performance benchmark:
 - Example: Behavioral Health Performance Measure X
 - High Performance Benchmark: 70.0%
 - Baseline: 55.0%

- Gap: 70% – 55% = 15%
- Gap Closure: 10% of 15% = 1.5%
- 55% + 1.5% = 56.5%
- CY2026 Target: 56.5%

Note: Sub-rate 1 for Q-FUA, Q-FUI, and Q-FUM will utilize the Gap Closure Methodology with the following adjusted benchmarks: Medicaid 10th, 25th, and 50th percentile benchmarks as the minimum, median, and high performance benchmarks.

Ratio-Based Risk Adjusted Measures

For all three risk-adjusted QIP measures (Q-PCR, Q-CDI, and Q-SSI), where performance is measured by an observed to expected (O/E) ratio, individual QIP entity performance targets will be calculated using the following Calibrated O/E Threshold methodology:

- For each measure, the QIP entity’s O/E ratio is converted to a Calibrated O/E using the National or State Median O/E ratio, as follows:

$$\text{Calibrated O/E} = (\text{Entity O/E}) / (\text{National/State Median O/E})$$

All QIP entity performance targets for these three measures are set using the Calibrated O/E, as follows.

Table 3: QIP Entity Calibrated O/E

Achievement Value	QIP Entity Calibrated O/E
AV = 1.0	<0.9
AV = 0	≥0.9

Example

- QIP entity’s Q-PCR O/E ratio = 0.8834
- HEDIS PCR National Average O/E = 0.9880
- Entity’s Calibrated O/E ratio = (Entity’s O/E / National Median O/E) = 0.8834 / 0.9980 = 0.8851
- **Outcome** → The entity’s calibrated O/E <0.9. The entity would therefore receive an AV of 1, indicating that it performed better than expected (compared to the national average).

E. ACHIEVEMENT VALUES

For QIP CY2026, a measure’s AV will be based on Table 4, updated to provide more gradient AVs. The table defines how AVs are assigned based on the measure performance relative to benchmarks and gap closure targets, and distinguishes between priority measures and elective measures.

Over-performance values are no longer applicable due to more available AV scoring.

Table 4: Measure Performance Achievement Values

Measure Performance in Prior CY	AV = 0	AV = 0.25	AV = 0.33	AV = 0.5	AV = 0.66	AV = 0.75	AV = 1.0	AV = 1.5 (Priority Measures) <u>or</u> AV = 1.25 (Elective Measures)	AV = 2.0 (Priority Measures) <u>or</u> AV = 1.5 (Elective Measures)
≥ High performance benchmark	Performance < high performance benchmark	NA	NA	NA	NA	NA	Elective Measure: Performance ≥ high performance benchmark	NA	Priority Measure: Performance ≥ high performance benchmark
< High performance benchmark Note: Performance must be greater than or equal to the 25 th percentile	<25% of the applicable 10% gap is closed	≥25% to <33% of the applicable 10% gap is closed	≥33% to <50% of the applicable 10% gap is closed	≥50% to <66% of the applicable 10% gap is closed	≥66% to <75% of the applicable 10% gap is closed	≥75% to <100% of the applicable 10% gap is closed	≥100% to <150% of the applicable 10% gap is closed	≥150% to <200% of the applicable 10% gap is closed	≥200% of the applicable 10% gap is closed

Performance Categories:

- **≥ High Performance Benchmark**
- **< High Performance Benchmark**
 - Note:** Performance must be ≥25th percentile to be eligible for AV scoring if below the high-performance benchmark.
- **Priority Measures:**
 - Must meet or exceed the **25th percentile** to be eligible for AV scoring.
 - If performance is **≥ high performance benchmark**, full AV is awarded.
- **Elective Measures:**
 - If performance is **≥ high performance benchmark**, AV = 1.0.
 - If performance is **≥ 200% of the applicable 10% gap**, AV = 1.5.
 - If performance is **≥ 150% to < 200%**, AV = 1.25.
- **High Performance Benchmark:** Achieving or exceeding this benchmark results in the highest AV scores.
- If performance is **below the high performance benchmark**, AV is determined based on the percentage of the **10% gap** closed.

AVs for measures with sub-rates, unless otherwise specified in the measure specifications, use the following criteria:

- 1) The QIP entity reports separate numerators and denominators for each measure sub-rate, per the measure specifications.
- 2) Each sub-rate is assessed for an AV using the methodology described in Table 4.
- 3) The total AV for each sub-rated measure is an average of the individual sub-rate AVs. As such, the total AV will be a unique percentage (i.e., not necessarily 0.0, 0.5, 0.75, or 1.0). Measures with sub-rates will have the total AV exclude an accountable sub-rate with a denominator of <30 if conditions described in [V.A. Minimum Data Reporting Requirements](#) are present.

Measure and Sub-Rate Exceptions

- 1) **Q-AIS-E: Adult Immunization Status (AIS-E)**
 - Rate 5 (Immunization Status: Hepatitis B) will be required for reporting for informational purposes only and will not contribute to the AV for this measure.
- 2) **Q-BCS-E: *Breast Cancer Screening (BCS-E)**
 - The Ages 42-51 sub-strata will be required for reporting for informational purposes only and will not contribute to the AV for this measure.
 - The Ages 52-74 sub-strata will be reported as pay-for-performance, and will be the only determinant of the AV for this measure.
 - The Ages 42-74 Total rate will be required for reporting for informational purposes only, and will not contribute to the AV for this measure.

- 3) **Q-DSF-E: *Depression Screening and Follow-Up For Adolescents and Adults (DSF-E)**
 - Follow-up rate will be informational only.
 - Numerator 1 (Screening) will be pay-for-performance.
- 4) **Q-CMS138: *Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**
 - Rate 1 (screening) will be required for reporting for informational purposes only and will not contribute to the AV for this measure.
 - Rate 2 (tobacco users who received tobacco cessation intervention) and Rate 3 (screening and received tobacco cessation intervention if identified as a tobacco user) will be reported as pay-for-performance, and will determine the AV for this measure. Refer to [V.A. Minimum Data Reporting Requirements](#) for an additional exception for any CY in which this measure is reported as a Priority Measure.
- 5) **Q-FUM: *Follow-Up After Emergency Department Visit for Mental Illness (FUM)**
 - Rate 2 (percentage of ED visits at a QIP entity facility for which the person received follow-up within 7 days) will be required for reporting for informational purposes only, and will not contribute to the AV for this measure.
- 6) **Q-FUA: *Follow-Up After Emergency Department Visit for Substance Use (FUA)**
 - Rate 2 (percentage of ED visits at a QIP entity facility for which the person received follow-up within 7 days) will be required for reporting for informational purposes only, and will not contribute to the AV for this measure.
- 7) **Q-FUI: Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)**
 - Rate 2 (percentage of visits or discharges for which the person received follow-up within 7 days) will be required for reporting for informational purposes only, and will not contribute to the AV for this measure.
- 8) **Q-FUAH: Percentage of Acute Hospital Stay Discharges Which Had Follow-Up Ambulatory Visits Within 7 Days Post Hospital Discharge**

This measure will be required for informational purposes only, and will not have an AV.
- 9) **Q-ECM: Number of Individuals Enrolled in ECM**

This measure will be required for informational purposes only, and will not have an AV.
- 10) **Q-COMS: Number of and Percentage of Eligible Individuals Receiving Community Supports, and Number of Unique Community Supports Received by Individuals**

This measure will be required for information purposes only, and will not have an AV.

F. CALCULATING PAYMENTS

CY2026 Payment Release

DHCS will release two payments to QIP entities that are eligible and elect to receive interim payment. The interim payment will be based on the entity's prior CY's Quality Score, and 50 percent of the prior CY's earnable payment will be made to the MCPs in September, a year after the CY. Then, the total balance of earnable payment will be reconciled with current CY Quality Score and paid to MCPs in March, two years after the CY.

If a QIP entity has a zero Quality Score in the prior three years, it is not eligible for the interim payment. A zero score refers to overall performance, not to performance on a single measure.

Final QIP payments are based on base payment determined by a Quality Score. A Quality Score measures the sum of the AVs for all measures reported on by the QIP entity system, divided by the number of measures selected for reporting. Each QIP entity's maximum allowable payment amount is multiplied by the QIP entity's Quality Score to determine the base payment. AVs are based on performance per [Section VI. E. Achievement Values](#).

Each QIP entity's base payment amounts will be used to determine the QIP entity's final QIP payment. The final QIP payment must not be more than 100 percent of the QIP entity's maximum allowable payment amount.

The State will require MCPs, via its contracts, APLs, or similar instructions, to make final QIP payments to contracted QIP entities. The State will identify the amount of final QIP payments each MCP must make to each contracted QIP entity, with the sum of these amounts not to exceed the total funds available in the applicable QIP CY.

DPH Systems

The maximum allowable payment amount that may be earned by a DPH system (i.e., the amount earned if the DPH system attains all selected quality targets) will be equal to the total funds available in the applicable QIP CY, multiplied by the DPH system's proportion of total Medi-Cal managed care members served in the CY, relative to all other participating DPH systems. If there is more than one MCP in the DPH system's service area, the final QIP payment to the DPH system will be allocated proportionally among MCPs.

DMPHs

The maximum allowable payment amount that may be earned by a DMPH is equal to its specific allocation. This includes a minimum allocation of at least 0.75 percent of the total amount available to all DMPHs for a specific CY. If a DMPH is allocated the minimum, this will proportionally adjust all other DMPH allocations. The allocation for all other DMPHs will be determined by two factors:

- 1) 40 percent by the number of measures the DMPH commits to report, proportionate to other DMPHs. DHCS will administer a new measure commitment survey during the first quarter of CY2026 (60 calendar days after the release of the CY2026 Reporting Manual) in order for DMPHs to commit to the minimum number of measures the DMPH will report on beginning in CY2026.
- 2) 60 percent by the most current annual Medi-Cal revenue, proportionate to other participating DMPHs.