2026

Hospital P4P

Pay for Performance Program Technical Guide

IEHP

Inland Empire Health Plan

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PROGRAM OVERVIEW

Inland Empire Health Plan (IEHP) is pleased to announce the ninth year of the Hospital Pay For Performance (P4P) Program for IEHP contracted hospitals servicing Riverside and San Bernardino counties. This program underlines IEHP's commitment and support to our partners by providing financial rewards to hospitals that meet quality performance targets and demonstrate high-quality care to IEHP members.

The 2026 Hospital P4P Program will award financial incentives for 9 individual measures.

A. **Measures** feature clinical and transition of care quality indicators that highlight a hospital's commitment to excellence in patient outcomes as well as a data sharing measure to promote increased visibility and monitoring of key performance indicators, patient outcomes, and clinical excellence.

   1. Quality Measure Composite
   2. BETA HEART® Program
   3. Hospital Quality Rating
   4. Patient Experience: Percentile Achievement
   5. Healthcare Associated Infections - SIR Ratio Achievement
   6. Quality Improvement Activity: Clinical Variation Reduction
   7. Quality Improvement Activity: Patient Experience
   8. Adult Flu Vaccination
   9. Manifest MedEx Active Data Sharing

☑ Participation Requirements

General

- Hospitals located within Riverside and San Bernardino counties or other identified areas with emerging needs for IEHP members must be active and contracted with IEHP for the Medi-Cal and Covered California population.
- Hospitals must have a signed Incentive Program contract amendment prior to the start of the Hospital P4P performance period, in order to be eligible to receive incentive dollars.
- Hospitals must provide appropriate contact information for all hospital-based physician groups and engage in connecting key stakeholders from these hospital-contracted groups with IEHP as requested; including but not limited to topics regarding Covered California Network Adequacy.
- Hospitals must be in good standing with IEHP throughout the program year. This is defined as a Provider currently contracted with Plan for the delivery of services, not pursuing any litigation or arbitration or has a pending claim pursuant to the California Government Tort Claim Act (Cal. Gov. Code §§ 810, et. seq.), which is unresolved filed against Plan at the time of program application or at the time additional funds may be payable and has demonstrated the intent, in Plan's sole determination, to continue to work together with Plan on addressing community and member issues. Additionally, at the direction of the CEO or their designee, Plan may determine that a Provider is not in good standing based on relevant quality, payment, or other business concerns.
- Hospitals must provide Electronic Medical Record (EMR) access to IEHP for members with IEHP as the primary or secondary payor. This access facilitates treatment, payment, and operational processes, including but not limited to care coordination, utilization management (preauthorization, concurrent and retrospective review), and quality review. Access must be provided to IEHP by January 31, 2026, and continue through the entire measurement year (2026).
    - Due to their unique structure, Critical Access Hospitals are offered an alternative and must provide either EMR access (as above) and/or remain in good standing with IEHP's Integrated Transitional Care team throughout the program year. This is defined as a Hospital engaging in discussions, meetings and performance improvement related to member care transitions as requested and appropriate based on member volume and need.
- Hospitals that plan to discontinue a service line must be compliant with all requirements set forth by local, regional, and/or national governing agencies and regulatory bodies. Additionally, the Hospital must notify IEHP of the anticipated change at least 90 days prior to implementation.

- Hospitals are required to be in good standing with IEHP's Quality Management and Grievance and Appeals Departments. This includes but not limited to: Timely response for information/response related to Grievances, Potential Quality Issues, Corrective Action Plans, etc.
- IEHP will re-evaluate performance for the Hospital P4P Quality Measure Composite, for the entire measurement year, at the close of the 2026 reporting period.

Participation With/In Other Entity Reporting

- Hospitals with Maternity service lines must actively participate in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center Reporting, submit data timely as per CMQCC standards and have a signed CMQCC authorization release to share hospital-level results with IEHP.
- Hospitals must be in good standing with Dexur. Please reference Appendix 1 for additional details.
- Hospitals must be compliant with the requirements of the California Health and Human Services Agency (CalHHS) Data Exchange Framework (DxF). Please visit the https://dxf.chhs.ca.gov/for-participants/ for additional information.
- Hospitals must participate in the ©Cal Hospital Compare "Healthcare Organizations Leading SUD Care - Hospital Self-Assessment" by June 26th, 2026. Please visit https://calhospitalcompare.org/programs/sud-care-honor-roll/ for details.
- Hospitals must have a current participation agreement (PA) in place with Manifest MedEx (MX). The executed PA using MX's post-merger PA structure must be in place at the beginning of each quarter to qualify for the quarterly incentive.

Data Submission

- Hospitals must complete an update to their IEHP Hospital Profile as requested, approximately twice per year.
- Hospitals must participate in disease-specific gap analyses and other strategic planning-related requests as requested by IEHP and relevant to hospital scope. This will be limited to no more than six requests throughout the calendar year.

☑ Program Terms and Conditions

- The Hospital must be in good standing with IEHP.
- Participation in the Hospital P4P Program, as well as acceptance of incentive payments, does not modify or supersede any terms or conditions of any agreement between IEHP and Providers, whether that agreement is entered before or after the date of this communication.
- There is no guarantee of future funding for, or payment under, any IEHP Provider incentive program. The Hospital P4P Program and/or its terms and conditions may be modified or terminated at any time, with or without notice, at IEHP's sole discretion.
- Criteria for calculating incentive payments are subject to change at any time, with or without notice, at IEHP's sole discretion.
- In consideration of IEHP's offering of the Hospital P4P Program, participants agree to fully and forever release and discharge IEHP from all claims, demands, causes of action, and suits, of any nature, relating to or arising from the offering by IEHP of the Hospital P4P Program.
- The determination of IEHP regarding performance scoring and payments under the Hospital P4P Program is final. If a potential discrepancy in performance scoring is identified, the responsibility will be on the Provider to demonstrate measure compliance.
- As a condition of receiving payment under the Hospital P4P Program, Hospitals must be contracted with IEHP at the time of payment.
- P4P data is subject to retrospective validation and must pass all quality assurance checks. Recoupment of incentive payments may occur if the retrospective review fails medical record or other validation.
- Hospitals will not charge IEHP for medical records for routine operational activities including, but not limited to: HEDIS, Risk Adjustment and Financial Audit.

Incentive payments may be reduced or withheld as follows:

- (All Measures) Late or incomplete submissions: Late or incomplete submissions will generally not be accepted. If a late submission or resubmission is approved due to extenuating circumstances, hospitals may be penalized via a percent reduction in available/earned dollars. The specific percent reduction will be shared with the hospital at the time of approval for late submission or resubmission.
- (Manifest MedEx) Late or incomplete data feeds will generally not be accepted. If a late data feed or replay is approved due to extenuating circumstances, hospitals may be penalized via a percent reduction in available/earned dollars. The specific percent reduction will be shared with the hospital at the time of approval for late data feed or replay.

NOTE: If you disagree with your hospital's quarterly performance report, you may submit a request for dispute research by submitting dispute inquiries to QualityPrograms@iehp.org. All disputes for research must be submitted within 90 days of the distributed quarterly performance report.

Definitions

Critical Access Hospital (CAH)

CAHs are specially designated hospitals located in rural areas. These may be more than 35 miles from the nearest hospital or more than 15 miles in areas with mountainous terrain or only secondary roads or designated by the State as a "necessary provider" of health care services to residents in the area. These facilities maintain no more than 25 inpatient beds that can be used for inpatient or swing-bed (skilled nursing facility level care), maintain an average length of stay of 96 hours or less for inpatients, and provide emergency services 24 hours a day, 7 days a week. Hospice agencies may contract with critical access hospitals to provide inpatient hospice care, included in the 25-bed maximum. Critical access hospitals may also operate a psychiatric and/or rehabilitation distinct part unit of up to 10 beds each. For purposes of the P4P program, Critical Access Hospital (CAH) designation is determined by Accreditation/Licensure. Hospitals must demonstrate qualification upon request by IEHP.

Eligible Hospital Providers

The following list outlines 34 IEHP contracted hospitals who are eligible to participate in the 2026 Hospital Pay for Performance Program. Eligibility is subject to change at any time as determined by the Health Plan.

1. Arrowhead Regional Medical Center
2. Barstow Community Hospital
3. Bear Valley Community Hospital
4. Chino Valley Medical Center
5. Colorado River Medical Center
6. Community Hospital of San Bernardino
7. Corona Regional Medical Center
8. Desert Regional Medical Center
9. Desert Valley Hospital
10. Eisenhower Medical Center
11. Hemet Global Medical Center
12. Hi-Desert Medical Center
13. Inland Valley Hospital
14. John F. Kennedy Memorial Hospital
15. Loma Linda University Children's Hospital
16. Loma Linda University Medical Center
17. Loma Linda University Medical Center Murrieta
18. Menifee Global Medical Center
19. Montclair Hospital Medical Center
20. Mountains Community Hospital
21. Palo Verde Hospital
22. Parkview Community Hospital Medical Center
23. Pomona Valley Hospital Medical Center
24. Providence St. Mary Medical Center
25. Rancho Springs Hospital
26. Redlands Community Hospital
27. Ridgecrest Regional Hospital
28. Riverside Community Hospital
29. Riverside University Health System Medical Center
30. San Antonio Regional Hospital
31. San Gorgonio Memorial Hospital
32. St. Bernardine Medical Center
33. Temecula Valley Hospital
34. Victor Valley Global Medical Center

Financial Overview

The annual budget for the 2026 Hospital P4P Program is $64,800,000. The table below summarizes the Hospital P4P Program budget for the year, outlining dollars available per measure.

2026 HOSPITAL P4P PROGRAM		
Measure Name		**Financial Allocation**
Measures		
1.	Quality Measure Composite	$20,000,000
2.	BETA HEART® Program	$5,950,000
3.	Hospital Quality Rating	$10,000,000
4.	Patient Experience: Percentile Achievement	$3,500,000
5.	Healthcare Associated Infections - Standardized Infection Ratio Achievement	$2,000,000
6.	Quality Improvement Activity: Clinical Variation Reduction	$6,800,000
7.	Quality Improvement Activity: Patient Experience	$4,250,000
8.	Adult Flu Vaccination	$1,230,000
9.	Manifest MedEx Active Data Sharing	$10,000,000
IEHP Programmatic Support		
10.	Dexur^	$1,070,000
Total Budget		**$64,800,000**

^ These dollars are not eligible for hospital payout; IEHP has allocated these dollars to support the continued administration of Dexur.

☑ Payment Schedule

The chart below summarizes the Hospital P4P Program payment schedule. There are a total of five payments beginning February 2026, extending through September 2027.

PAYMENT SCHEDULE						
2026 Measurement Period						
Measure Name		**Payout #1 Feb. 2026**	**Payout #2 Nov. 2026**	**Payout #3 Feb. 2027**	**Payout #4 May 2027**	**Payout #5 Sept. 2027**
Measures						
1.	Quality Measure Composite		Quarters 1 & 2			Quarters 3 & 4
2.	BETA HEART® Program	Reference measure details for payment schedule				
3.	Hospital Quality Rating	Reference measure details for payment schedule				
4.	Patient Experience: Percentile Achievement		Quarters 1 & 2		Quarters 3 & 4	
5.	Healthcare Associated Infections - Standardized Infection Ratio Achievement				Quarters 1-4	
6.	Quality Improvement Activity: Clinical Variation Reduction	Reference measure details for payment schedule				
7.	Quality Improvement Activity: Patient Experience	Reference measure details for payment schedule				
8.	Adult Flu Vaccination		Quarter 1			Quarter 4
9.	Manifest MedEx Active Data Sharing		Quarter 1	Quarter 2	Quarter 3	Quarter 4

2026 Hospital P4P Payment Calculation:

Incentive amounts for each measure are determined annually and may be set as follows:

- Flat rate
- Pool:
  - o Divided among qualifying hospitals,
  - o Based on IEHP member admissions, or
  - o Weighted based on additional factors
- Pay per encounter

Payments based on IEHP member admissions are calculated as follows:

Step 1: Determine the Percentage of Total Admissions per Hospital
[Total IEHP Admissions for Hospital in the Quarter] ÷
[Total IEHP Admissions for All Eligible Hospitals in the Quarter]
= Percentage of Total Admissions

Step 2: Determine the Amount of P4P Dollars Available per Hospital
[Percentage of Total Admissions] X [Total Quarterly P4P Dollars Available]
= Total P4P Dollars Available per Hospital per Quarter

EXAMPLE: *Hospital X*

Step 1: Determine the Percentage of Total Admissions per Hospital
IEHP Admissions for Hospital X in Quarter 1 2024 = 3,000
Total IEHP Admissions for All Hospitals in Quarter 1 2024 = 16,000
3,000 ÷ 16,000 = 0.1875

Step 2: Determine the Amount of P4P Dollars Available per Hospital
0.1875 X $6,000,000 = $1,125,000 Available for Hospital X for All Measures per Quarter

Hospital Quality Star Rating Payment Calculation:

Payments for the Hospital Quality Rating are determined based on the following formula:

Step 1: Determine the Hospital Encounter Index
[IEHP admissions per hospital % converted into the 4-tier patient encounter load weighting scale]

Step 2: Determine the Hospital Payment Factor
[Hospital Quality Star Rating x Hospital Encounter Index]

Step 3: Determine the Weighted Incentive Payout per eligible hospital
[(Hospital Payment Factor ÷ Sum of eligible Hospital Payment Factors) × Measure Incentive Pool]

Reporting Calendar

The below chart summarizes the 2026 Hospital P4P Program deliverables.

2026 REPORTING CALENDAR			
JANUARY 2026			
Date	**Measure**	**Measurement Period^**	**Data Source**
Monday, January 5, 2026	HCAHPS Data	07/2025 - 12/2025	Hospital to submit to Dexur
Friday, January 23, 2026	BETA HEART® Program, Milestone #1	Q1 2026	Hospital to submit to IEHP
	BETA HEART® Program, Milestone #2A		BETA will confirm hospital completion with IEHP
	QIA: Clinical Variation Reduction (CVR), Milestone #1 and #2		Hospital to submit to IEHP
	QIA: Patient Experience, Milestone #1A		Hospital/Vendor to submit to IEHP
Friday, January 30, 2026	NHSN Accelerated Reporting (Dexur)	November 2025	Hospital to submit to NHSN
FEBRUARY 2026			
Date	**Measure**	**Measurement Period^**	**Data Source**
Thursday, February 5, 2026	HCAHPS Data	08/2025 - 01/2026	Hospital to submit to Dexur
Friday, February 20, 2026	QIA: Patient Experience, Milestone #1B	Q1 2026	Hospital/Vendor to submit to IEHP
Friday, February 27, 2026	Hospital Profile Update 1 of 2	NA	Hospital to update Hospital Profile in IEHP's Provider Portal
	Chart Abstracted Data	Q3 2025	Hospital to submit to Dexur
	NHSN Accelerated Reporting (Dexur)	December 2025	Hospital to submit to NHSN
	SIERA or 837 data files to Dexur	Q4 2025	Hospital to submit to Dexur
MARCH 2026			
Date	**Measure**	**Measurement Period^**	**Data Source**
Thursday, March 5, 2026	HCAHPS Data	09/2025 -2/2026	Hospital to submit to Dexur
Friday, March 27, 2026	NHSN Accelerated Reporting (Dexur)	January 2026	Hospital to submit to NHSN
Tuesday, March 31, 2026	QIA: CVR, Milestone #3	Q1 2026	Hospital to submit to IEHP
	Dexur: Goals/Interventions		Hospital to submit to Dexur

2026 REPORTING CALENDAR

APRIL 2026

Date	Measure	Measurement Period^	Data Source
Sunday, April 5, 2026	HCAHPS Data	10/2025 - 03/2026	Hospital to submit to Dexur
Friday, April 24, 2026	NHSN Accelerated Reporting (Dexur)	February 2026	Hospital to submit to NHSN
Thursday, April 30, 2026	QIA: Patient Experience, Milestone #2	Q2 2026	Hospital/Vendor to submit to IEHP

MAY 2026

Date	Measure	Measurement Period^	Data Source
Tuesday, May 5, 2026	HCAHPS Data	11/2025 - 04/2026	Hospital to submit to Dexur
Friday, May 29, 2026	NHSN Accelerated Reporting (Dexur)	March 2026	Hospital to submit to NHSN
	SIERA or 837 data files to Dexur	Q1 2026	Hospital to submit to Dexur
	Chart abstracted data to Dexur	Q4 2025	Hospital to submit to Dexur

JUNE 2026

Date	Measure	Measurement Period^	Data Source
Friday, June 5, 2026	HCAHPS Data	12/2025 - 05/2026	Hospital to submit to Dexur
Monday, June 15, 2026	Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate	Q1 2026	CMQCC
	Plan All-Cause Readmission Observed to Expected (O/E) Ratio		IEHP Claims/Encounters
	Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days		
	Follow-Up After Emergency Department Visit for People With High- Risk Multiple Chronic Conditions		
	Post Discharge Follow-up Within Seven Days of Discharge		
	Manifest MedEx Data Quantity/ Validation		
Friday, June 26, 2026	©Cal Hospital Compare "Healthcare Organizations Leading SUD Care - Hospital Self-Assessment"	Please see Cal Hospital Compare for details	Hospital to submit evidence of submission to IEHP; Submission should include indicator that the assessment was successful electronically submitted to Cal Hospital Compare

2026 REPORTING CALENDAR

JUNE 2026

Date	Measure	Measurement Period	Data Source
Friday, June 26, 2026	NHSN Accelerated Reporting (Dexur)	April 2026	Hospital to submit to NHSN
Tuesday, June 30, 2026	QIA: CVR, Milestone #3	Q2 2026	Hospital to submit to IEHP
	QIA: CVR, Milestone #4		Hospital to submit confirmation to IEHP
	QIA: Patient Experience, Milestone #3		Hospital/Vendor to submit to IEHP
	QIA: Patient Experience, Milestone #4		
	Dexur: Goals/Interventions Updates		Hospital to submit to Dexur

JULY 2026

Date	Measure	Measurement Period^	Data Source
Sunday, July 5, 2026	HCAHPS Data	01/2026 - 06/2026	Hospital to submit to Dexur
Friday, July 24, 2026	NHSN Accelerated Reporting (Dexur)	May 2026	Hospital to submit to NHSN

AUGUST 2026

Date	Measure	Measurement Period	Data Source
Wednesday, August 5, 2026	HCAHPS Data	02/2026 - 07/2026	Hospital to submit to Dexur
Friday, August 28, 2026	NHSN Accelerated Reporting (Dexur)	June 2026	Hospital to submit to NHSN
	SIERA or 837 data files to Dexur	Q2 2026	Hospital to submit to Dexur
	Chart abstracted data to Dexur	Q1 2026	
	Hospital Profile Update 2 of 2 due	NA	Hospital to update Hospital Profile in IEHP's Provider Portal

2026 REPORTING CALENDAR

SEPTEMBER 2026

Date	Measure	Measurement Period	Data Source
Saturday, September 5, 2026	HCAHPS Data	03/2026 - 8/2026	Hospital to submit to Dexur
Tuesday, September 15, 2026	Timely Postpartum Care	Q1 2026	IEHP Claims/Encounters
	Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate	Q2 2026	CMQCC
	Plan All-Cause Readmission Observed to Expected (O/E) Ratio		IEHP Claims/Encounters
	Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days		
	Follow-Up After Emergency Department Visit for People With High- Risk Multiple Chronic Conditions		
	Post Discharge Follow-up Within Seven Days of Discharge		
	Manifest MedEx Data Quantity/ Validation		
Friday, September 25, 2026	NHSN Accelerated Reporting (Dexur)	July 2026	Hospital to submit to NHSN
Wednesday, September 30, 2026	BETA HEART® Program, Milestone #2B	Q1 2026 - Q3 2026	BETA will confirm hospital completion with IEHP
	QIA: CVR, Milestone #3	Q3 2026	Hospital to submit to IEHP
	QIA: Patient Experience, Milestone #3		Hospital/Vendor to submit to IEHP
	QIA: Patient Experience, Milestone #4		
	Dexur: Goals/Interventions Updates		Hospital to submit to Dexur

OCTOBER 2026

Date	Measure	Measurement Period	Data Source
Monday, October 5, 2026	HCAHPS Data	04/2026 - 09/2026	Hospital to submit to Dexur
Friday, October 30, 2026	NHSN Accelerated Reporting (Dexur)	August 2026	Hospital to submit to NHSN

2026 REPORTING CALENDAR

NOVEMBER 2026

Date	Measure	Measurement Period	Data Source
Thursday, November 5, 2026	HCAHPS Data	05/2026 - 10/2026	Hospital to submit to Dexur
Friday, November 27, 2026	NHSN Accelerated Reporting (Dexur)	September 2026	Hospital to submit to NHSN
	SIERA or 837 data files to Dexur	Q3 2026	Hospital to submit to Dexur
	Chart abstracted data to Dexur	Q2 2026	

DECEMBER 2026

Date	Measure	Measurement Period	Data Source
Saturday, December 5, 2026	HCAHPS Data	06/2026 - 11/2026	Hospital to submit to Dexur
Tuesday, December 15, 2026	BETA HEART® Program, Milestone #2C	Q1 2026 - Q4 2026	BETA will confirm hospital completion with IEHP
	BETA HEART® Program, Milestone #3		
	Timely Postpartum Care	Q2 2026	IEHP Claims/Encounters
	Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate	Q3 2026	CMQCC
	Plan All-Cause Readmission Observed to Expected (O/E) Ratio		IEHP Claims/Encounters
	Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days		
	Follow-Up After Emergency Department Visit for People With High- Risk Multiple Chronic Conditions		
	Post Discharge Follow-up Within Seven Days of Discharge		
	Manifest MedEx Data Quantity/ Validation		
Wednesday, December 23, 2026	NHSN Accelerated Reporting (Dexur)	October 2026	Hospital to submit to NHSN

2026 REPORTING CALENDAR			
DECEMBER 2026			
Date	**Measure**	**Measurement Period**	**Data Source**
Monday, December 28, 2026	QIA: CVR, Milestone #3	Q4 2026	Hospital to submit to IEHP
	QIA: CVR, Milestone #5		Hospital to submit achievement to IEHP
	QIA: Patient Experience, Milestone #4		Hospital/Vendor to submit to IEHP
	QIA: Patient Experience, Milestone #5		Vendor to submit to IEHP
	Dexur: Goals/Interventions Updates		Hospital to submit to Dexur
	Dexur: Share CMS Preview Reports	2026	Hospital to submit to Dexur

^ The measurement period may occur prior to 2026. This structure accommodates retrospective data as a result of established data collection timeframes and ensures the hospital remains in good standing with the requirements located in Appendix 1.

2026 HP4P REPORTING CALENDAR			
JANUARY 2027			
Date	**Measure**	**Measurement Period**	**Data Source**
Tuesday, January 5, 2027	HCAHPS Data	07/2026 - 12/2026	Hospital to submit to Dexur
Friday, January 29, 2027	NHSN Accelerated Reporting (Dexur)	November 2026	Hospital to submit to NHSN
FEBRUARY 2027			
Date	**Measure**	**Measurement Period**	**Data Source**
Friday, February 5, 2027	HCAHPS Data	08/2026 - 12/2026	Hospital to submit to Dexur
Friday, February 26, 2027	Chart Abstracted Data	Q3 2026	Hospital to submit to Dexur
	NHSN Accelerated Reporting (Dexur)	December 2026	Hospital to submit to NHSN
	SIERA or 837 data files to Dexur	Q4 2026	Hospital to submit to Dexur

2026 HP4P REPORTING CALENDAR

MARCH 2027

Date	Measure	Measurement Period	Data Source
Friday, March 5, 2027	HCAHPS Data	09/2026 - 12/2026	Hospital to submit to Dexur
Monday, March 15, 2027	Timely Postpartum Care	Q3 2026	IEHP Claims/Encounters
	Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate	Q4 2026	CMQCC
	Plan All-Cause Readmission Observed to Expected (O/E) Ratio		IEHP Claims/Encounters
	Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days		
	Follow-Up After Emergency Department Visit for People With High- Risk Multiple Chronic Conditions		
	Post Discharge Follow-up Within Seven Days of Discharge		
	Manifest MedEx Data Quantity/ Validation		

APRIL 2027

Date	Measure	Measurement Period	Data Source
Sunday, April 5, 2027	HCAHPS Data	10/2026 - 12/2026	Hospital to submit to Dexur

MAY 2027

Date	Measure	Measurement Period	Data Source
Tuesday, May 5, 2027	HCAHPS Data	11/2026 - 12/2026	Hospital to submit to Dexur
Friday, May 28, 2027	Chart abstracted data to Dexur	Q4 2026	Hospital to submit to Dexur

JUNE 2027

Date	Measure	Measurement Period	Data Source
Saturday, June 5, 2027	HCAHPS Data	12/2026	Hospital to submit to Dexur
Tuesday, June 15, 2027	Timely Postpartum Care	Q4 2026	IEHP Claims/Encounters

Supplemental Reporting Calendar:

In addition to the above reporting calendar, hospital teams that are responsible for the submission of data files may reference the supplemental reporting calendar below.

These deliverables are noted in the overarching reporting calendar above and have been listed separately here for ease of reference.

NHSN/SIERA/CHART ABSTRACTED DATA FILE DUE DATES^				
Due Date: ***	**NHSN Data to CDC/Dexur** **	**SIERA or 837 Files to Dexur***	**Chart Abstracted Data to Dexur**	**HCAHPS Data to Dexur**
	Accelerated Monthly Reporting Data Period	**Accelerated Quarterly Reporting Data Period**	**Quarterly Reporting Data Period**	**Monthly Reporting Data Period**
January 30, 2026	November 2025			Rolling 6 months of rolling data; HCAHPS data is due on the 5th of every month with performance year 2026 final data due Jun. 5th 2027 Please see Appendix 1: Dexur Good Standing Criteria for details
February 27, 2026	December 2025	Q4 2025	Q3 2025 (IQR & OQR)	
March 27, 2026	January 2026			
April 24, 2026	February 2026			
May 29, 2026	March 2026	Q1 2026	Q4 2025 (IQR & OQR)	
June 26, 2026	April 2026			
July 24, 2026	May 2026			
August 28, 2026	June 2026	Q2 2026	Q1 2026 (IQR & OQR)	
September 25, 2026	July 2026			
October 30, 2026	August 2026			
November 27, 2026	September 2026	Q3 2026	Q2 2026 (IQR & OQR)	
December 23, 2026	October 2026			
January 29, 2027	November 2026			
February 26, 2027	December 2026	Q4 2026	Q3 2026 (IQR & OQR)	
May 28, 2027	NA		Q4 2026 (IQR & OQR)	
June 5, 2027				

* *Quarterly reporting is effective approximately 60 days (eight weeks) after the close of the measurement quarter.*

** *Monthly reporting is effective approximately 60 days (eight weeks) after the close of the measurement month.*

*** *The measurement period may occur prior to 2026. This structure accommodates retrospective data as a result of established data collection timeframes and ensures the hospital remains in good standing with the requirements located in Appendix 1.*

^ *Data submitted by the corresponding due date will be frozen and used for the associated measure outcomes and payments. Data submitted after the submission deadline will be accurately reflected on the Dexur Platform but may not match values in the HP4P scorecard for the associated measures.*

IQR: Inpatient Quality Reporting

OQR: Outpatient Quality Reporting

Performance Targets

The chart below summarizes the Hospital P4P Program measures and the performance goals.

2026 MEASURE PERFORMANCE TARGETS			
Program Measures			
Measure Name		**Data Source**	**2026 Performance Targets**
1.	Quality Measure Composite	IEHP Claims/ Encounters and CMQCC	Quality Measure Composite score of ≥ 2.0
2.	BETA HEART® Program	Hospital/ BETA	See measure details for milestones
3.	Hospital Quality Rating	Dexur/CMS	See measure details for performance target
4.	Patient Experience: Percentile Achievement	Dexur	≥50th percentile performance in each recognized domain
5.	Healthcare Associated Infections - Standardized Infection Ratio Achievement	Dexur	See measure details for performance target
6.	Quality Improvement Activity: Clinical Variation Reduction	Hospital/JC	See measure details for milestones
7.	Quality Improvement Activity: Patient Experience	Hospital/ Vendor	See measure details for milestones
8.	Adult Flu Vaccination	Manifest MedEx	See measure details for milestones
9.	Manifest MedEx Active Data Sharing	Manifest MedEx	All conditions must be met: 1) Hospital is actively sharing data elements with MX per quarter 2) Hospital must submit all required P4P data elements for all hospital events throughout the entire measurement period
IEHP Programmatic Support			
10.	Dexur	Dexur	Please see Appendix 1 for Dexur Good Standing Criteria

CMS: Centers for Medicare and Medicaid Services

CMQCC: California Maternal Quality Care Collaborative

JC: Joint Commission

2026 HOSPITAL P4P MEASURES

NEW

☑ Measure Name: *Quality Measure Composite*

The Hospital P4P Quality Measure Composite summarizes performance across multiple individual measures to provide an overall assessment of quality of care provided to IEHP members. This measure combines the following measures into a single score:

- Plan All-Cause Readmissions Observed-to-Expected (O/E) Ratio
- Timely Postpartum Care
- Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days
- Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions – Seven Days
- Nulliparous Term Singleton Vertex Cesarean Delivery Rate
- Post Discharge Follow-Up Within Seven Days of Discharge

Quality Measure Composite Scoring

Hospital performance for each quality measure will be given a Measure Composite Score. Measure Composite Scores are assigned based on the Performance Tier Goal achieved (i.e., Performance Tier 1 = one point, Performance Tier 2 = two points, Performance Tier 3 = three points, Performance Tier 4 = four points, Performance Tier 5 = five points) for each measure.

The following formula will be used to calculate the Measure Composite Score:

- **Measure Composite Score** = Performance Tier Goal achieved * Measure Weight

The following formula will be used to calculate the Initial Quality Measure Composite Score:

- **Initial Quality Measure Composite Score** = Sum of Scorable Measure Composite Score / Sum of Scorable Measure Weights

Final Quality Measure Composite Score – The Initial Quality Measure Composite Score is translated to the Final Quality Measure Composite Score as outlined below:

2026 HOSPITAL P4P QUALITY MEASURE COMPOSITE GOALS		
Initial Quality Measure Composite Score	**Final Quality Measure Composite Score**	**Percent of Payment Allocation***
≥ 0.750000 and < 1.250000	1.0	Hospital performance not eligible for Quality Measure Composite payment
≥ 1.250000 and < 1.750000	1.5	
≥ 1.750000 and < 2.250000	2.0	40%
≥ 2.250000 and < 2.750000	2.5	50%
≥ 2.750000 and < 3.250000	3.0	60%
≥ 3.250000 and < 3.750000	3.5	70%
≥ 3.750000 and < 4.250000	4.0	80%
≥ 4.250000 and < 4.750000	4.5	90%
≥ 4.750000 and ≤ 5.000000	5.0	100%

** Hospital Quality Measure Composite Final Score must be a 2.0 or higher to qualify for incentive payment.*

Quality Measure Composite Score – Tier Goals

2026 HOSPITAL P4P QUALITY MEASURE PERFORMANCE GOALS:						
Measure Name	**Performance Tier 1**	**Performance Tier 2**	**Performance Tier 3**	**Performance Tier 4**	**Performance Tier 5**	**Weight**
PCR: Plan All Cause Readmissions[1]	>1.2831	≤1.2831 to >1.1462	≤1.1462 to >1.0441	≤1.0441 to >0.9598	≤0.9598	3
PPC-Post: Postpartum Care[1]	<78.1%	≥78.1% to <82.48%	≥82.48% to <85.15%	≥85.15% to <88.32%	≥88.32%	1
FUA/FUM: Follow-up After ED Visit for Substance Use Disorder or Mental Health[1]	<26.42%	≥26.42% to <34.21%	≥34.21% to <41.74%	≥41.74% to <50.72%	≥50.72%	1
FMC: Follow-up After ED Visit for People with Multiple High-Risk Chronic Conditions[2]	<50.58%	≥50.58% to <56.44%	≥56.44% to <62.19%	≥62.19% to <72.09%	≥72.09%	1
NTSV: Nulliparous Term Singleton Vertex Cesarean Delivery Rate[3]	>26.19%	≤26.19% to >25.19%	≤25.19% to >24.19%	≤24.19% to >23.60%	≤23.60%	3
PDFU: Post-Discharge Follow-up[4]	<39.18%	≥39.18% to <41.91%	≥41.91% to <45.21%	≥45.21% to <43.67%	≥46.37%	1

[1] *Goals based on 2025 (MY 2024) NCQA Medicaid Quality Compass*

[2] *Goals based on 2024 (MY 2023) NCQA Medicare Quality Compass*

[3] *NTSV Performance Tier 1 to Tier 4 goals based on MY 2024 Network Hospital Performance. Tier 5 goal set based on Healthy People 2030 target*

[4] *Goals based on MY 2024 Network Hospital Performance*

Plan All-Cause Readmission Observed-to-Expected (O/E) Ratio

This measure captures the number of acute inpatient stays during the measurement period that are followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of acute readmission for IEHP members 18-64 years old. Acute inpatient stays include any observation days that exceed one day.

Methodology:

The Healthcare Effectiveness Data and Information Set (HEDIS®) modified measure called "Plan All-Cause Readmissions" (PCR) is utilized to determine the 30-day readmission rate for IEHP Hospitals. Data are reported in the following categories:

1) Count of Observed 30-Day Readmissions
2) Count of Expected 30-Day Readmissions
3) Count of Index Hospital Stays (IHS)
4) Observed-to-Expected Ratio

The Observed-to-Expected Ratio (O/E Ratio) is the final measure used to determine hospital performance.

Numerator: Count of Observed 30-Day Readmissions

Count all acute readmissions for any diagnosis within 30 days of the Index Discharge Date. The readmission can occur at any hospital, including a hospital separate from the hospital being measured.

The following are excluded from the Count of Observed 30-Day Readmissions:

- Principal diagnosis of pregnancy
- Principal diagnosis of a condition originating in the perinatal period
- Nonacute inpatient stays
- Principal diagnosis of maintenance chemotherapy
- Principal diagnosis of rehabilitation
- Organ transplant
- Potentially planned procedures without a principal acute diagnosis

Denominator: Count of Expected 30-Day Readmissions

The first step in calculating the Rate of Expected 30-Day Readmissions is to calculate the count of Expected 30-Day Readmissions. The count of Expected Readmissions is determined in two steps:

1) Calculate the Estimated Readmission Risk for each Index Hospital Stay (IHS) by summing the following risk adjustment weights:
    - Age/gender
    - Surgeries
    - Discharge clinical condition
    - Comorbidities

2) Sum the Estimated Readmission Risk for all IHS in the reporting period

Next, the Expected 30-day Readmission Rate is calculated by taking the count of Expected 30-Day Readmissions and dividing it by the Count of Index Hospital Stays.

Index Hospital Stays (IHS):

Count of all acute inpatient discharges on or between January 1 and December 31 of the measurement year (2026). The index stay must occur at the hospital being measured.

The following are excluded from the Index Hospital Stay:

- Principal diagnosis of pregnancy
- Principal diagnosis of a condition originating in the perinatal period
- Member died during the stay
- Non-Acute inpatient stays
- Hospice care
- Same-day discharges. Observation stays will be excluded if the observation stay meets the same-day discharge criteria. Same-day discharge criteria is defined as having the same admit and discharge date.
- Outliers: Members with four or more index hospital stays between January 1 and December 31 of the measurement year (2026)

Observed-to-Expected Ratio:

The Rate of Observed 30-Day Readmissions divided by the Rate of Expected 30-Day Readmissions.

Minimum Denominator Requirement*:

The count of Index Hospital Stays must be 20 or greater for this measure to be eligible for payment.

**This does not apply to Critical Access Hospitals (CAHs).*

Eligibility Criteria:

To be eligible for this measure, members must be enrolled with IEHP 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date. No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date. No gap is allowed during the 30 days following the Index Discharge Date.

Notes:

- All hospital claims received by IEHP are included in the calculation of this measure regardless of payment decision (i.e., all payment statuses are counted, including denied status claims).
- Medi-Medi members are excluded from this measure. Medi-Medi members are defined as members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

Timely Postpartum Care

Healthcare Effectiveness Data and Information Set (HEDIS®) modified measure called Timely Postpartum Care is utilized to determine the percentage of live birth deliveries that had an outpatient postpartum visit on or between 7 and 84 days after delivery.

The eligible population in this measure meets all the following criteria:

- Continuous IEHP enrollment 43 days prior to delivery through 60 days after delivery.
- No allowable gaps in IEHP enrollment.

Numerator:

Members in the denominator who had a postpartum visit on or between 7 and 84 days after delivery.

Refer to the Timely Postpartum Care code list located on the IEHP P4P Program website.

Denominator:

Members who delivered a live birth during the measurement year (2026).

Minimum Denominator Requirement*:

The denominator must be 10 or above for this measure.

**This does not apply to Critical Access Hospitals (CAHs).*

Note:

- Medi-Medi members are excluded from this measure. Medi-Medi members are defined as members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days

The Healthcare Effectiveness Data and Information Set (HEDIS®) modified measure called Follow-Up Care for Mental Health and Substance Use Disorder Emergency Department – Seven Days is utilized to determine the percentage of emergency department (ED) visits for members ages 6 years and older who had a principal diagnosis of a substance use disorder, any diagnosis of a drug overdose, mental illness, or intentional self-harm, and had a follow-up visit with a Provider within seven days.

Below is a list of practitioner types/visits that count towards this measure:

- PCP
- MD or DO specializing in psychiatry
- Licensed psychologist
- Certified clinical social worker
- RN certified as a psychiatric nurse
- Licensed or certified professional counselor with a master's degree or doctoral degree in marital and family therapy
- PA certified to practice psychiatry
- Certified Community Mental Health Center/Clinic
- Peer Support Services and Residential Treatment
- Behavioral Healthcare Setting and Psychiatric Collaborative Care Management

Refer to the Substance Disorders and Mental Health Diagnosis list located on the IEHP P4P Program Website. These lists include diagnoses for substance use disorder, drug overdose, mental illness, or intentional self-harm.

Refer to the FUA and FUM code list located on the IEHP P4P Program website.

Numerator:

Members in the denominator who had an in-person or telemedicine follow-up visit within seven days of discharge from the ED with a practitioner who is addressing the substance use or mental illness disorder.

Denominator:

Members ages 6 years and older who had a discharge from an ED with a principal diagnosis of a substance use disorder, any diagnosis of a drug overdose, mental illness, or intentional self-harm.

Minimum Denominator Requirement*:

The denominator must be 10 or above for this measure.

**This does not apply to Critical Access Hospitals (CAHs).*

Note:

- Medi-Medi members are excluded from this measure. Medi-Medi members are defined as members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions – Seven Days

This modified Healthcare Effectiveness Data and Information Set (HEDIS®) measure captures the percentage of members, 18 years and older with multiple high-risk chronic conditions who visited the Emergency Department (ED) and had a follow-up service within seven days of the ED visit.

Members are included in this measure if they had an ED visit and have two or more diagnoses of the following chronic conditions prior to the ED visit:

- Acute Myocardial Infarction
- Atrial Fibrillation
- Asthma, Chronic Obstructive Pulmonary Disease, or unspecified Bronchitis
- Alzheimer's disease or other similar disorders
- Chronic Kidney Disease
- Depression
- Heart Failure
- Transient Ischemic Attack and Stroke

Numerator:

A follow-up service within seven days after the ED visit for members in the denominator. Include follow-up visits that occur on the date of the ED visit. Any of the following meet criteria for follow-up visits:

- Outpatient visit, Telephone visit, E-visit or Virtual check-in
- Transitional Care Management Services
- Case Management Visits
- Complex Care Management Services
- Outpatient or Telehealth Behavioral Health Visit
- Intensive Outpatient Encounter or Partial Hospitalization
- Community Mental Health Center Visit
- Electroconvulsive Therapy
- Substance Use Disorder Service
- Substance Use Disorder Counseling and Surveillance

Refer to the FMC Follow-Up code list located on the IEHP P4P Program website.

Denominator:

The number of ED visits from members 18 years and older with multiple high-risk chronic conditions on the date of the ED visit.

Minimum Denominator Requirement*:

The denominator must be 20 or above for this measure.

**Critical Access Hospitals (CAHs) must have a minimum denominator of 5 or above for this measure.*

Note:

- Medi-Medi members are excluded from this measure. Medi-Medi members are defined as members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate

The California Maternal Quality Care Collaborative (CMQCC) calculates a standardized measure that assesses the rate of Cesarean births, focusing on the all-important first birth. This measure is known as the Nulliparous Term Singleton Vertex (NTSV) Cesarean Birth Rate. It identifies the proportion of live babies born at or beyond 37 weeks of gestation to women in their first pregnancy, which are singleton (no twins or beyond) and in the vertex presentation (no breech or transverse positions) via Cesarean birth. The United States Department of Health and Human Services, in its Healthy People 2020 project, simplified the name for non-obstetric audiences to "Low-Risk Cesarean Birth Among First-Time Pregnant Women." This is somewhat imprecise, as some higher-risk patients remain in the denominator but have very little impact.

Joint Commission subsequently adopted this metric in 2010 and now requires all hospitals with more than 300 births to report their results as part of the Perinatal Core Measure Set.

The metric has also been adopted by the Leapfrog Group and the Centers for Medicare and Medicaid Services. Several states also require hospital reporting as part of their Medicaid quality initiatives. The NTSV Cesarean Birth measure was re-endorsed as one of the National Quality Forum's (NQF) Perinatal and Reproductive Health measures in 2016, and the Joint Commission is now the steward of the measure.

Methodology:

Hospitals with maternity service lines must actively participate in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center Reporting and have a signed CMQCC authorization release in place to share hospital-level results with IEHP by February 15, 2026.

All hospitals participating in the IEHP Hospital P4P Program must report their rates according to the CMQCC reporting guidelines and timeframes and authorize CMQCC to give IEHP access to the reported rates. IEHP will receive hospital-specific rates from CMQCC according to the reporting timeline noted in the Reporting Calendar.

A lower rate in this measure indicates better performance.

Post Discharge Follow-Up Within Seven Days of Discharge

This measure captures the number of discharges during the measurement period for high-risk members, 18 years of age and older, with a follow-up outpatient visit within seven days of hospital discharge.

Methodology:

As part of IEHP's population health strategy, all IEHP members are designated a risk level based on all available utilization and diagnostic data available to the plan. Members fall into one of three risk categories: High, Rising and Low Risk. IEHP leverages the John Hopkins ACG System to determine member risk level using industry-validated risk stratification algorithms and incorporates social determinant of health tools to supplement the ACG system. For this measure, IEHP is leveraging the final administrative risk determination of "High Risk" at the time of admission.

Numerator:

High-risk members who had a follow-up visit with a practitioner within seven days of discharge. A practitioner for this measure is defined as:

- A Primary Care Provider or Specialty Care Provider
- A physician or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwife) who offers primary care or specialty care medical services
- Note: Licensed practical nurses, registered nurses and pharmacists are not considered PCPs or Specialists

Refer to the PDFU code list located on the IEHP P4P Program website.

Denominator:

All acute and nonacute inpatient discharges during the measurement period for high-risk members.

IEHP utilizes the HEDIS® modified measure denominator specifications for Transition of Care (TOC) to determine the initial denominator.

To be eligible for this measure, IEHP members must be enrolled with IEHP on the date of discharge through 30 days after discharge (31 total days).

Minimum Denominator Requirement*:

The denominator must be 10 or above for this measure.

**Critical Access Hospitals (CAHs) must have a minimum denominator of 5 or more members, in the performance quarter, to be assessed for the Post Discharge Follow-Up measure.*

Notes:

- Only the last discharge is counted if the discharge is followed by a readmission within seven days of the initial discharge.
- Urgent Care visits are not accepted for this Post Discharge Follow-Up measure.
- Medi-Medi members are also excluded from this measure. Medi-Medi members are defined as members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

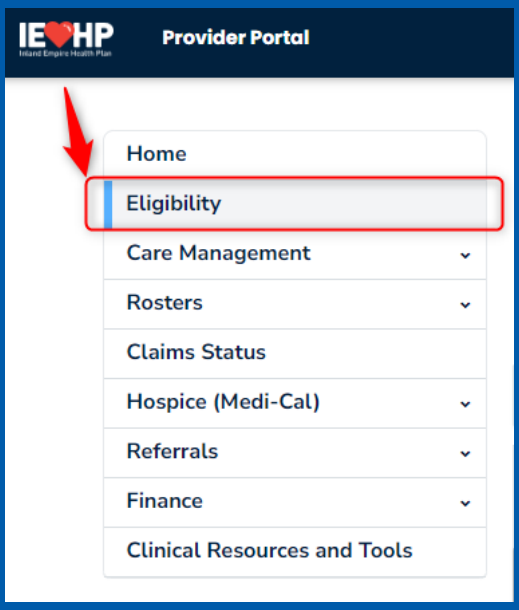
The following are excluded from the measure:

1. Members discharged to Hospice
2. Members discharged to a Skilled Nursing Facility
3. Members presenting for Delivery

To view an IEHP Member's current high-risk score, hospitals can log into the secure IEHP Provider Portal and follow these steps:

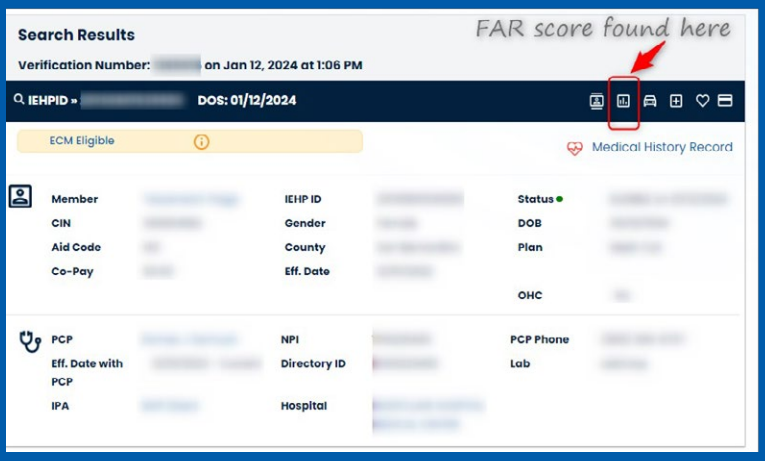
Step 1:

Locate IEHP member in eligibility on IEHP Secure Provider Portal



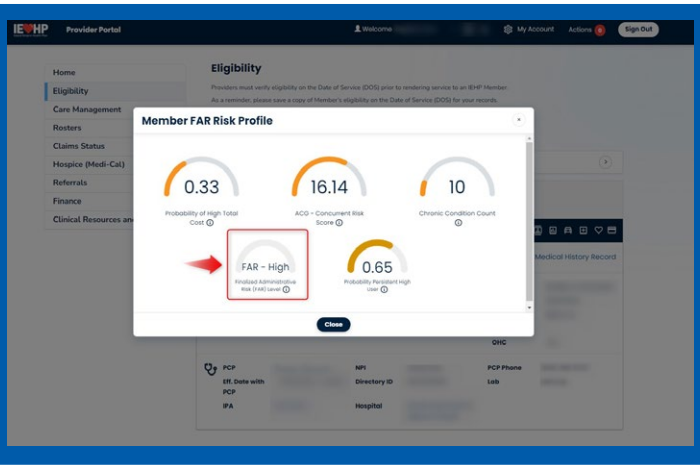
Step 2:

Click icon for "FAR score"



Step 3:

View "FAR score"



☑ Measure Name: *BETA HEART® Program*

BETA HEART® (healing, empathy, accountability, resolution, and trust) is a coordinated effort designed to guide health care organizations in implementing a reliable and sustainable culture of safety grounded in a philosophy of transparency. The goals of the program are to develop an empathic and clinically appropriate process that supports the healing of the patient and clinician after patient harm; ensure accountability for the development of reliable systems that support the provision of safe care; provide a mechanism for early, ethical resolution when harm occurs as a result of medical error or inappropriate care; and instill trust in all clinicians and patients.

BETA HEART is an interactive, and collaborative process supporting the organization, its staff, and patients. Hospitals progress through five individual yet integrated domains, each an essential component of the culture of safety and transparency:

1. **Safety Culture:** Administering a scientifically validated, psychometrically sound safety culture survey to measure staff perceptions of safety and engagement, as well as sharing and debriefing results. The Culture domain includes the implementation of a Just Culture of accountability and the sharing of lessons learned.
2. **Rapid Event Response and Analysis:** A formalized process for early identification of adverse events and rapid response to them. This includes applying cognitive interviewing tactics to collect information. The event analysis process includes obtaining input from patients and families, and integrates human factors science, systems analysis, and the principles of Just Culture. Organizations learn to differentiate between strong and weak performance improvement action items and apply strong actions that result in improved systems.
3. **Communication and Transparency:** The organization commits to honest and transparent communication with patients and family members harmed during care or after an adverse event. Participating organizational leaders, physicians and staff will take a communication assessment, identify, and designate a communication consult or resource team, and develop processes for ensuring empathic and transparent communication with patients and families that begins early and continues through the course of the event review. Findings from the event review and actions taken are shared with patients and families.
4. **Care for the Caregiver:** Development and implementation of an organizational proactive peer support program that ensures emotional support for members of the health care team involved in or impacted by an adverse event.
5. **Early Resolution:** A process for resolution when harm is deemed a result of inappropriate care or medical error. Resolution may include financial or non-financial means and is dependent upon the impact of the event and the actions needed to be taken, to the best of the organization's ability, to make the patient/family whole.

The five domains are introduced through distinct workshops attended by participating hospital teams. The order and timeframe for the implementation of domains will vary by organization.

Program materials may be found at https://betahg.com/risk-management-and-safety/risk-management-and-safety-consulting-services/. For most hospitals, completing a domain will require a significant investment of time and effort. The BETA program team and faculty are available to provide multi-faceted support to participating hospitals throughout the implementation.

Performance Requirements Overview – All eligible hospitals

Hospitals must complete each milestone (as described under "Hospital Requirements" below), by the associated completion due date to qualify for the milestone incentive dollars.

MILESTONE #	2026 INCENTIVE MILESTONES	HOSPITAL REQUIREMENTS	COMPLETION DUE DATE	INCENTIVE PER HOSPITAL
1	Participation Requirements	Complete contracting with BETA Healthcare. Deliverable: Hospital to submit copy of signed opt-in agreement and proof of payment to BETA Healthcare Group	1/23/26	$12,500
2	Engage in the Process	A. Complete Annual Pulse Survey: Organizational HEART Lead to distribute a pulse survey to several (groups) within the organization as required by BETA. Please reference the BETA HEART® Opt In Agreement for additional details including requirement for survey responses and audience. Deliverable: BETA will confirm hospital completion with IEHP	1/23/2026	$5,000

MILESTONE #	2026 INCENTIVE MILESTONES	HOSPITAL REQUIREMENTS	COMPLETION DUE DATE	INCENTIVE PER HOSPITAL
2	Engage in the Process	B. Regional Trainings: Attend regional training(s) for each of the domain(s) requested for validation. This includes any previously validated domains and regional trainings. A minimum of 5 hospital representatives for the hospital-specific BETA operational team must attend the required regional trainings to quality for incentives related to this milestone and domain validations. Up to three attendees may be carried over from prior year training with two new attendees at a minimum. *Note: Hospitals who share the same executive leadership will need to ensure that each hospital is represented with the minimum number of representatives per hospital, per regional training. Deliverable: BETA will confirm hospital attendance with IEHP	9/30/2026	$45,000
		C. BETA HEART Dashboard Develop a BETA HEART dashboard for monitoring key metrics and outcomes. Dashboard will be reviewed with BETA during the quarterly meetings. The hospital team is responsible for sharing the dashboard with leadership and the governing board on a quarterly basis. Submission must include Culture of Safety Survey results and dashboard reflective of key metrics/outcomes. Deliverable: BETA will confirm hospital completion with IEHP	12/15/2026	$26,250

MILESTONE #	2026 INCENTIVE MILESTONES	HOSPITAL REQUIREMENTS	COMPLETION DUE DATE	INCENTIVE PER HOSPITAL
3	Validation in Selected Domain(s)	Obtain Domain Validation in a New Domain* Once domain elements are complete, hospitals may request validation for up to one new domain: 1) Select domain for validation 2) Schedule validation of selected domain(s) with BETA 3) Participate in all aspects of domain validation process (document review, interviews, observation) 4) Obtain validation in selected domain(s) *To be eligible for incentive dollars associated with domain validation, the hospital must validate in a new domain. While organizations are encouraged to pursue more than one domain, IEHP will incentivize completion of one. Additionally, the participating hospitals will need to revalidate meeting subsequent validation criteria for domains validated as part of the 2024/2025 HP4P program. Participating hospitals will need to ensure that they allow ample time to coordinate validation planning and scheduling with the BETA Team. BETA will communicate the deadline for scheduling your validation visit. Deliverable: BETA will confirm hospital achievement with IEHP	12/15/26	$86,250

Exclusions -

Hospitals who achieved domain validation as part of the 2024 and 2025 HP4P Program are not eligible to earn incentive dollars for revalidating in the same domain(s).

To qualify for incentive dollars, the hospital must select a new domain for validation. If hospital is continuing with domain validation, the hospital will be revalidated for all previously achieved domain(s) as part of the 2024 and 2025 HP4P Programs. If the hospital does not successfully revalidate meeting subsequent validation criteria for domains previously achieved as part of the HP4P program, the hospital will not be eligible for incentive dollars related to any new domain validated in 2026.

Payment Methodology – All eligible hospitals:

The following table describes the payment amounts available for hospitals to earn for achieving each milestone along with the associated P4P payment cycle dates.

BETA HEART® PAYMENT SCHEDULE				
Milestone	**Incentive Milestones**	**Incentive per Hospital**	**Performance Period**	**P4P Payment Distribution**
1	Complete contracting with BETA Healthcare	$12,500	Q1 2026	February 2026
2	Complete Annual Pulse Survey	$5,000	Q1 2026	
	Regional Training Attendance*	$45,000	Q1-Q3 2026	February 2027
	BETA Heart Dashboard	$26,250	Q1 - Q4 2026	February 2027
3	Obtain Validation in selected Domain	$86,250	Q1 - Q4 2026	February 2027
Milestones Total		**$175,000**		

**While regional trainings are incentivized separately, they are also a milestone for validation. Hospitals must meet regional training requirements to be eligible for the domain validation incentive.*

☑ Measure Name: *Hospital Quality Rating*

IEHP is committed to partnering with hospitals to support the delivery of high-quality care, ensuring exceptional patient outcomes. One way we evaluate a hospital's overall quality is through a Hospital Quality Rating system, which offers a standardized assessment of the care provided.

IEHP has established a goal that by the end of 2026, ≥75% of IEHP network hospitals will have a Hospital Quality Rating of 3 stars or higher. To promote this goal, IEHP offers financial incentives to hospitals that achieve a quality rating of ≥3 in the **Alternative Hospital Quality Rating** (Medi-Cal)*. If achieved, the hospital is then eligible to receive additional incentive dollars for a ≥3 stars Centers for Medicare & Medicaid Services (CMS) Hospital Quality Star Rating.

The Alternative Hospital Quality Rating leverages Readmission and Mortality outcomes for the Medi-Cal population and Safety and Patient Experience outcomes for the All Payor population via data captured within the Dexur platform and includes measures as outlined below:

1. Mortality (1 measure) – in-hospital mortality rates utilizing Medi-Cal encounters
2. Readmission (1 measure) – readmissions within 30 days to the same hospital utilizing Medi-Cal encounters
3. Patient Experience (8 measures) – observes the patient's perspective on the hospital care received
4. Safety of Care (6 measures) – observes potentially preventable injury and complications during hospitalization**

***Excludes Critical Access Hospitals*

The Hospital Quality Star Rating is a trusted, robust, validated methodology designed by the Center for Outcomes Research and Evaluation (CORE) project team in collaboration with CMS. This rating system was launched in July 2015 and since its inception has been modified into a statistically sound, comprehensive evaluation tool to summarize hospital performance that patients and consumers can easily interpret. Hospital quality outcomes and results are categorized into five major areas. These measure groups for the July 2026 star rating system are:

1. Mortality
2. Safety of Care
3. Readmission
4. Patient Experience
5. Timely & Effective Care

Methodology:

Alternative Hospital Quality Rating:*:

The Hospital Quality Rating will be calculated using data from the Dexur platform. A 1-to-5-star rating scale utilizing the same percentiles as the CMS Hospital Quality Star Rating will be used to derive the Hospital Quality Rating.

CMS Hospital Quality Star Rating:

The CMS Hospital Quality Star rating will be obtained from the officially released 2026 CMS Hospital Quality Star Rating via https://www.medicare.gov/care-compare/. A 1-to-5-star rating system is utilized with 5 stars representing the highest score possible.

Performance Requirements Overview – All eligible hospitals

Measure Goal:

- Metric 1: Achieve a ≥3 Alternative Hospital Quality Rating (Medi-Cal Rating*)
- Metric 2: Achieve a ≥3 CMS Hospital Quality Star Rating

Payment Methodology – All eligible hospitals:

The following describes the allocated payment amounts available for hospitals to earn for achieving the measure goals:

2026 HOSPITAL QUALITY RATING PAYMENT			
Goal		**Total Eligible**	**Payment Period**
Metric 1	Hospital achieves a ≥3 Alternative Hospital Quality Rating (Medi-Cal Rating*)	75%	November 2026
Metric 2	Hospital achieves a ≥3 CMS Hospital Quality Star Rating	25%	
*Hospital **must** achieve metric 1 to be eligible for metric 2*			

**Critical Access Hospitals who do not achieve a Medi-Cal Rating will leverage the All Payor Rating for their performance indicator utilizing the same methodology utilized for the Medi-Cal Rating.*

☑ Measure Name: *Patient Experience: Percentile Achievement*

Patient Experience is an important component of health care quality and continues to be a top priority for hospitals. A positive experience can lead to better health outcomes and sustained engagement. Many hospitals elected to participate in the 2025 Hospital P4P Quality Improvement Activity (QIA) specific to Patient Experience. The QIA highlighted a need to continue to recognize and reward hospitals achieving outcomes-based improvements as a result of their performance improvement efforts in the following Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS) domains of focus:

- Communication with doctors
- Discharge information
- Overall rating of the hospital
- Likelihood to recommend the hospital

This measure compares the top-box score (%) for each domain against the 50th percentile scores as referenced in nationally published HCAHPS Percentiles Table (referenced below).

Methodology:

The top-box score is the most positive response to the survey questions. Percentiles allow IEHP to compare a hospital's "top-box" score relative to national rates for each of the survey domains.

Top box scores for each domain will be converted into percentile rankings utilizing the nationally published HCAHPS Percentile Table (referenced below)*. Hospitals will receive incentive dollars for each domain achieving ≥50th percentile performance. Top-box scores will be obtained from the Dexur platform.

Numerator:

Numerator varies by survey domain as follows:

Communication with Doctors – The number of respondents selecting "Always" for all three questions that comprise the Communication with Doctors composite:

- How often doctors treated you with courtesy and respect
- How often doctors listened carefully to you
- How often doctors explained things in a way you could understand

Discharge Information – The number of respondents selecting "Yes" for all two questions that comprise the Discharge Information composite:

- Did staff communicate about the help they would need at home after they left the hospital
- Did patients receive written information about symptoms or health problems to look out for after they left the hospital

Overall Rating of Hospital – The number of respondents rating the hospital a '9' or '10'

Likelihood to Recommend – The number of respondents selecting "Definitely yes"

Denominator:

The total number of survey responses.

Determining Percentile:

The outcome of the calculation of numerator divided by denominator is compared to the 50th Percentile top-box score from the HCAHPS Percentiles Table.

50th Percentile Performance Target:

TOP BOX SCORE				
Hospital Percentile	Communication with Doctors	Discharge Information	Overall Rating	Likelihood to Recommend
50th	79%	87%	72%	70%

**Percentiles are based off surveys of patients discharged between July 2023 and June 2024. Obtained from https://www.hcahpsonline.org. Centers for Medicare & Medicaid Services, Baltimore, MD. August 04, 2025.*

NEW

☑ Measure Name: *Healthcare Associated Infections – SIR Ratio Achievement*

IEHP is committed to ensuring that all patients receive safe, high-quality care. In support of this commitment, we aim to support hospitals in their ongoing efforts to improve performance in preventing Healthcare Associated Infections (HAIs).

There are many risk factors that expose patients to HAIs including hospitalization, invasive procedures, and variation from best practices. HAIs are associated with morbidity and mortality rates underscoring the serious risk posed to patient safety (CDC, 2025). Therefore, this measure is designed to recognize and reward hospitals that meet the established performance standards defined by ©The Leapfrog Group, reinforcing our goal of excellence in patient safety and quality of care.

Methodology:

Hospitals must actively participate with Dexur as data outcomes will be obtained via the Dexur Platform.

Performance Requirements Overview – All eligible hospitals

Achieve a Standardized Infection Ratio (SIR) at or below the "Achieved the Standard" targeted rate as defined by ©The Leapfrog Group for the following HAIs:

- Central line-associated bloodstream infections (CLABSIs)
- Catheter-associated urinary tract infections (CAUTIs)
- Methicillin-resistant Staphylococcus aureus infections (MRSA)
- Clostridioides difficile infections (CDIs)
- Surgical site infections from colon surgery (SSI: Colon)

Payment Methodology:

IEHP will assess the hospitals performance* annually and will leverage the most up-to-date scoring algorithm publicly available as of December 31st, 2026.

- Each HAI will be assessed independently

*Performance targets can be found by visiting, https://www.leapfroggroup.org/survey-materials/scoring-and-results.

References:

Centers for Disease Control and Prevention (CDC). (2025). About HAIs. https://www.cdc.gov/healthcare-associated-infections/about/index.html

Information related to The Leapfrog Group adapted from: https://www.leapfroggroup.org/survey-materials/scoring-and-results.

☑ Measure Name: *Quality Improvement Activity: Clinical Variation Reduction*

Clinical Variation Reduction (CVR) is a process that identifies evidence-based practices aimed at optimal clinical practices for specific diseases and leverages them to establish standardized care pathways. These pathways are designed to guide clinical decision-making and promote consistency in the delivery of care across providers and departments.

By minimizing variation, CVR initiatives support improvements in quality of care, enhance interdisciplinary team collaboration and contribute to a more cohesive patient experience. CVR efforts can have great impact on hospitals and patients by reducing potentially preventable complications, readmissions, and unexpected outcomes – advancing both operational efficiently and patient safety (Ardoin & Malone, 2019).

This measure encourages hospital to pursue certification with the Joint Commission to build Centers of Excellence within the space of Maternity, Sepsis or Palliative Care. Achieving certification will allow for the development of a robust quality-centric hospital network with as much reduction in variability as possible given the operational nuances and diversity within this network.

Performance Requirements Overview – All eligible hospitals

Obtain certification in one of the selected areas from Joint Commission (JC) utilizing the tiered structure set forth below.

Hospitals are not eligible for incentive dollars related to certifications previously achieved.

QUALITY IMPROVEMENT ACTIVITY: CLINICAL VARIATION REDUCTION TIERED CERTFICATON STRUCTURE		
Tier Level	**Tier Item**	**Hospital Requirements**
#1	Advanced Certification in Perinatal Care from JC	If hospital has achieved, or does not have maternal services, move to #2
#2	Sepsis Certification from JC	If hospital has achieved, move to #3
#3	Hospital-Based Palliative Certification from JC	If hospital has achieved, move to #4
#4	If hospital has achieved all certifications listed above, the hospital may submit to IEHP request to pursue alternative certification; subject to approval and based on clinical need.	

QUALITY IMPROVEMENT ACTIVITY: CLINICAL VARIATION REDUCTION			
Milestone #	**2026 Incentive Milestones**	**Hospital Requirements**	**Completion Due Date**
1	Establish or provide evidence of a current certification steering team**	Establish or demonstrate evidence of a current committee, workgroup, or task force that at minimum includes the following key representatives: a. Executive Sponsor (Senior/Executive Director or above) b. Physician champion (i.e., Hospitalist) c. Patient safety representative d. Quality representative e. Nurse leader	1/23/26
2	Participation	1) Hospital to select one certification for completion^ 2) Hospital to complete a participation agreement with IEHP outlining their intent to participate in this QIA and engage with Joint Commission for the formal certification process 3) Hospital to submit to IEHP data, as outlined in Appendix 2 for the past 12 months (10/01/24-9/30/25) i. Data should not include PHI	1/23/26
3	Quarterly Progress Updates**	Submit quarterly progress updates including progress toward certification and updated data outcomes utilizing metrics identified in Appendix 2	3/31/2026 6/30/2026 9/30/2026 12/28/2026
4	Apply for Certification	Hospital will apply for certification of selected measure through certifying body	6/30/26
5	Obtain Certification	Hospital will obtain certification from certifying body	12/28/26

***Please reference supplemental submission templates provided by IEHP.*

^Hospitals are encouraged to reach out to JC to confirm hospital eligibility.

Additional Participation Requirements:

As a requirement for program year 2026, in addition to specific milestones above, hospitals must actively participate in Advance Care Planning (ACP) health information exchange with CareDirectives or equivalent throughout the entire program year in order to receive incentives for this QIA. Participation will be reviewed at the close of each quarter to ensure ongoing adherence.

Payment Methodology:

The following table describes the payment amounts available for hospitals to earn for achieving each milestone along with the associated P4P payment cycle dates.

QUALITY IMPROVEMENT ACTIVITY: CLINICAL VARIATION REDUCTION PAYMENT SCHEDULE				
Milestone #	**2026 Incentive Milestones**	**Incentive per Hospital**	**Performance Period**	**P4P Payment Distribution**
1	Establish or provide evidence of a current Certification Steering Team	$80,000	Q1 2026	November 2026
2	Participation			
3	Quarterly Progress Updates	$20,000	Q1 2026 - Q4 2026	February 2027
4	Apply for Certification	$20,000	Q2 2026	February 2027
5	Obtain Certification	$80,000	Q4 2026	May 2027
	Milestones Total	**$200,000**		

Note:

- All incentives are provided in good faith. If a hospital does not complete the yearlong quality improvement activity as outlined or achieve certification, all incentives are subject to withhold from future incentive payments.

References:

Ardoin MD, D., & Malone, J. (2019). Reducing clinical variation to drive success in value-based care (part 1). HFMA. https://www.hfma.org/operations-management/care-process-redesign/reducing-clinical-variation-to-drive-success-in-value-based-care0/

☑ Measure Name: *Quality Improvement Activity: Patient Experience*

IEHP is focused on ensuring members discharged from network hospitals receive care and services that reflect cultural humility, respect and human-centered hospital care that aligns with our Mission, Vision and Values.

This measure encourages member network hospitals to participate in a Quality Improvement Activity (QIA) focused on a comprehensive and human-centered custom experience design. Through this endeavor, participating hospitals will be well-equipped to design and consistently deliver the personal, memorable, and high-quality health care experiences IEHP members desire and deserve.

Performance Requirements Overview – All eligible hospitals

Hospitals must complete each milestone (as described under "Hospital Requirements" below), by the associated completion due date to qualify for the milestone incentive dollars.

QUALITY IMPROVEMENT ACTIVITY: PATIENT EXPERIENCE:				
Milestone #	**2026 Incentive Milestones**	**Hospital Requirements**		**Completion Due Date**
1	Participation Requirements	A)	Complete contracting with an approved vendor** Deliverable: Confirmation of a fully executed contract with an approved experience design vendor	1/23/26
		B)	Complete onboarding/launch process with approved vendor Deliverable: Confirmation of completion of all vendor-required documents for onboarding/launch process (i.e., participant profiles, intake assessments, etc.) to include proof of payment.	2/20/2026
2	Engage in the Process	Hospital to complete an in-person design session held on the hospital campus with vendor Deliverable: Vendor or hospital submission of: agenda, presentation material outline, updated action plan and documentation of attendees (steering team required)		4/30/26
3		Hospital to complete two virtual hospital-focused Experience Design Activation Labs with vendor Deliverable: Vendor or hospital submission of: agenda, presentation material outline, updated action plan and documentation of attendees (steering team required)		6/30/2026 9/30/2026

QUALITY IMPROVEMENT ACTIVITY: PATIENT EXPERIENCE:			
Milestone #	**2026 Incentive Milestones**	**Hospital Requirements**	**Completion Due Date**
4	Ongoing Engagement	Hospital steering team must attend at least three quarterly 1:1 Hospital-Specific Office Hours Deliverable: Vendor or hospital submission of documentation of attendees for all steering team members	6/30/2026 9/30/2026 12/28/2026
5	Design Validation	Hospital participates in the validation of their new Experience Design Implementation Deliverable: Vendor submission of Experience Design Implementation Validation Report	12/28/26

**IEHP will need to review and approve the selected vendor. To facilitate this process, hospitals must submit details as outlined in the participation agreement to allow for the necessary review and approval. At minimum, the vendor must provide:*

- *Hospital-specific experience design services as defined as:*

  The comprehensive and human-centered process of creating a positive experience for patients and their families through all aspects of their health care journey. It considers the patient's entire experience, including all interactions, touchpoints, and outcomes, before, during and after visits–as well as considering the team member and provider experience. The goal is to improve the patient's clinical experience and create a personal, memorable, and mutually beneficial experience.
- *Curated experience design learning opportunities including in person and virtual design forums.*
- *A cohesive and coordinated approach to designing and improving the experience: Shifting from siloed, discrete efforts to a unified, orchestrated approach for improving hospital culture and overall patient experience.*
- *Education and guidance for bringing new-world solutions to existing patient experience efforts and preparing participants to serve as in-house experts in experience design.*
- *Experience design methods that equip participants with ready-to-implement tools and rapid experience activations that can be easily customized and uniquely applied to each participating hospital's areas of focus.*
- *Avenues for hospitals to complete all milestones as listed above.*

***Contract term must be no less than 1 year and extend through 12/31/2026*

Payment Methodology:

The following table describes the payment amounts available for hospitals to earn for achieving each milestone along with the associated P4P payment cycle dates.

QUALITY IMPROVEMENT ACTIVITY: PATIENT EXPERIENCE PAYMENT SCHEDULE				
Milestone #	**2026 Incentive Milestones**	**Incentive per Hospital**	**Performance Period**	**P4P Payment Distribution**
1	Participation Requirements	$100,000	Q1 2026	February 2026
2-3	Engage in the Process	$25,000	Q2 - Q3 2026	May 2027
4	Ongoing Engagement		Q2 - Q4 2026	
5	Design Validation		Q4 2026	
Milestones Total		**$125,000**		

Note:

- All incentives are provided in good faith. If a hospital does not complete the year-long quality improvement activity as outlined, all incentives are subject to withhold from future incentive payments.

☑ Measure Name: *Adult Flu Vaccination*

According to the Centers for Disease Control and Prevention (CDC), the flu can cause illness, hospitalization, and mortality yet more individuals can be protected from the flu through the flu vaccination (2024).

Therefore, IEHP has established a measure that incentivizes hospitals for each adult influenza vaccination administered to inpatient IEHP members 19 years of age and older as the vaccination remains a critical tool in preventing flu-related complications.

Methodology:

Hospital administration of flu vaccination will be captured through the Manifest MedEx HL7 VXU data feed. Hospitals may be asked to provide supplemental details.

Exclusions:

IEHP members less than 19 years of age and/or Medi-Medi members.

Performance Requirement Overview – All eligible Hospitals:

ADULT FLU VACCINATION - PERFORMANCE WINDOW:	
Data Capture Period	Flu Vaccination Administration Period
Q1 2026	01/01/2026 – 03/31/2026
Q4 2026	10/01/2026 - 12/31/2026

Payment Methodology:

ADULT FLU VACCINATION PAYMENT SCHEDULE		
Payment per Service	Performance Period	P4P Payment Distribution
$25/Vaccination	Q1 2026	November 2027
	Q4 2026	May 2027

References:

Centers for Disease Control and Prevention (CDC). (2024). Benefits of the Flu Vaccine. https:// www.cdc.gov/flu-vaccines-work/benefits/index.html

Note:

- Medi-Medi members are defined as members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

☑ Measure Name: *Manifest MedEx Active Data Sharing*

Manifest MedEx (MX) supports Health Information Exchange (HIE) connectivity across California. As the largest nonprofit health data network in California, Manifest MedEx connects hospitals, medical groups, IPAs, physician practices and health plans in the Inland Empire. Manifest MX is also a CalHHS Data Exchange Framework (DxF)-designated intermediary and helps organizations securely exchange data as required under the DxF.

Performance Requirements:

Metric 1 Data Quality:

- Hospitals must demonstrate active data sharing with Manifest MX by submitting all data types listed in the below table throughout the measurement period.
- Completeness of hospital data will be assessed monthly and quarterly to ensure data sharing is in place throughout the entire measurement period.
- Participants have 30 days from notification to resolve any identified issue and achieve passing status for the feed or segment.
    - Manifest MedEx will provide monthly reports as written notification of issues and relevant status updates.

This data sharing requirement aims to leverage new technology to support care transition processes between hospitals and providers. Compliance with this measure requires hospitals to report all discharges and admissions (including emergency room, acute, and subacute stays) to Manifest MX for all message types noted in the below table during the entire measurement period.

MX DATA CONTRIBUTION FOR HOSPITALS		
HL7 ADT data feed that complies with MX data sharing guidelines in production		
Admissions Data	Discharge Data	Diagnosis Data
HLF ORU/MDM data feed that complies with MX data sharing guidelines in production		
Lab Orders	Lab Results	Lab Documents
Pathology Documents	Radiology Documents	Chart Notes*
HL7 RDE data feed that complies with MX data sharing guidelines in production		
Prescription Medications/Orders		Medication Information (including SIG)
Delivery Route		Status
HL7 VXU data feed that complies with MX data sharing guidelines in production		
Immunization Data**		

* Chart notes include: History & Physical, discharge summary, consults, progress notes, surgical notes and procedure notes. These notes can be provided by HL7 Medical Document Management (MDM).

** Immunization data submitted to MX is separate from immunization reporting to California Immunization Registry (CAIR).

Metric 2 Data Quantity/Validation:

- On a quarterly basis, IEHP will review all submitted claims. We will verify that each claim for a patient encounter has a matching admission/arrival message (ADT HL7).
- This new requirement is intended to improve real-time care coordination by ensuring we have accurate and timely member information.

Payment Methodology:

The following describes the allocated payment amounts available for hospitals for achieving metrics 1 and 2.

Metric 1 Data Quality: 50% of total allocated incentive

- For General Acute Care Hospitals, each feed (ADT, ORU/MDM, RDE, VXU) accounts for 25% of the 50% total allocated incentive.
    - Hospitals must pass in all feeds to achieve full incentive.
- Due to the unique characteristics of Critical Access Hospitals (CAH), the following adjustment is made to provide additional resources to support the establishment and maintenance of the required data feeds for this measure:
    - A maximum of $15,000 is available for the measurement year
    - Incentives are awarded as follows:
        - $937.50 for each HIE feed (ADT, ORU/MDM, RDE, VXU) that
            a) is newly established during the quarter, or
            b) meets the quality threshold for the quarter

Metric 2 Data Quantity/Validation: 50% of total allocated incentive

- Payment for this incentive, which is up to 50% of the total available amount, will be based on the percentage of claims that have a matching admission message (ADT HL7).
    - For example, if 75% of claims match, the hospital will receive 75% of the 50% incentive.
- Critical Access Hospitals (CAHs) can earn up to $15,000 annually, calculated using the same validation process.

Technical Requirements:
Hospitals are required to send all fields listed in the technical specification documents on the IEHP.org website: https://www.providerservices.iehp.org/en/programs-and-services/provider-incentive-programs/pay-for-performance-program#hospital-P4P-program

Acronym Dictionary:
ADT: Admission, discharge, transfer message
HL7: Health level 7 standards development organization
MDM: Medical Document Management
ORM: Order Interface
ORU: Observation result message
RDE: Pharmacy/treatment encoded order message
VXU: Immunization data

APPENDIX 1: *Dexur Good Standing Criteria*

Hospitals must complete the following as per referenced timeframes and/or at least quarterly. Hospitals not meeting all criteria in a single quarter are at risk of forfeiture of all 2026 Hospital P4P incentives earned during that quarter for the following measures:

- Hospital Quality Rating
- Patient Experience: Percentile Achievement
- Healthcare Associated Infections - SIR Ratio Achievement

- Submit their SIERA data files to include Inpatient, ED, and Ambulatory data to Dexur on an accelerated quarterly* basis in an editable file report.
  - In lieu of SIERA data file submission, the hospital may submit the 837 Healthcare Claim file. Please note, for optimal use of the Dexur platform, it is recommended to submit the 837 data and to send the data monthly.

- Submit their chart abstracted and web-based measure data to Dexur on a quarterly basis.*

- Grant the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Group Access to Dexur to allow for downloadable HAI data.

- Submit individual survey-level HCAHPS responses through an automated process or by granting Dexur direct access to your HCAHPS vendor's reporting system.
  - This approach ensures detailed cohort-level analytics to enhance patient experience, align with plan goals, and maintain consistent monthly reporting.
  - Submit a rolling 6-month set of HCAHPS data on the 5th of every month.*

- Have a minimum of 3 active goals with at least one associated intervention per goal to improve IEHP Quality Rating/CMS Star Rating by March 31st, 2026.
  - Goals and interventions must be addressed by hospitals quarterly.

- Share all CMS Preview Reports with Dexur for purposes of reconciliation by 12/28/2026.

**Please see the reporting calendar and supplemental reporting calendar for data submission deadlines.*

APPENDIX 2: *QIA: Clinical Variation Reduction Data Element*

The below data elements are to be utilized by Hospitals who are participating in the QIA: Clinical Variation Reduction. These data requirements are to be utilized for submission of milestone #2 and milestone #3.

Data capture period is as follows:

Milestone #2: Baseline Data: 10/01/2024– 09/30/2025

Milestone #3:

- 03/31/2026 submission to include data from Q4 2025
- 06/30/2026 submission to include data from Q1 2026
- 09/30/2026 submission to include data from Q2 2026
- 12/28/2026 submission to include data from Q3 2026

DATA ELEMENTS	
Certifications	**i. Data should be provided in monthly or quarterly aggregates** **ii. Please do not include any PHI**
Advanced Certification in Perinatal Care	Measures associated with the Joint Commission Perinatal Care Measure Set: PC-01: Elective Delivery PC-02: Cesarean Birth PC-05: Exclusive Breast Milk Feeding PC-06: Unexpected Complications in Term Newborns
Sepsis	SEP-1 Sepsis Mortality Rate
Hospital-based Palliative Care	Measures associated with the Joint Commission Palliative Care Measure Set: PAL-01 Pain Screening PAL-02 Pain Assessment PAL-03 Dyspnea Screening PAL-04 Treatment Preferences and Goals of Care PAL-05 Treatment Preferences Discharge Document

Depending on the certification selected, the hospital may be required to collect/report data directly to Joint Commission as part of the certification process. These data elements may or may not match those listed in the table above. Hospitals are encouraged to reach out to the Joint Commission for additional information.

NOTES

Inland Empire Health Plan

iehp.org

Contact the Hospital Relations Service Team at:

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