



Quality Measures for Encounter Data (QMED 2.0)

Provider Training – October 1, 2026



What is Encounter Data and Why it's Important

Encounter Data is defined as the information that describes health care interactions between Members and Providers relating to the receipt of any item(s) or service(s) by a Member under the Managed Care Plan Contract. (It's a record of services rendered.)

- It captures **what services were delivered, to which patients, and with what diagnoses**, after the claim has been processed.

Why it Matters

- DHCS relies on this data to support program and population health oversight and to fulfill federal reporting requirements.
- Tracking member encounters is the primary way the state monitors care access, calculates future funding rates, and satisfies federal reporting mandates.



All Plan Letter 14-020 – Quality Measure for Encounter Data

Effective January 1, 2015, the Department of Health Care Services (DHCS) began to measure the quality of the managed care encounter data for completeness, accuracy, reasonability, and timeliness.

DHCS grades Managed Care Plan (MCPs) as “High-Performing,” “Low-Performing,” or “Non-Compliant,” in terms of encounter data quality, using the methodology described in the QMED document.



All Plan Letter 26-003 - Updates to DHCS QMED requirements

Beginning January 2026

1. The quality of managed care Encounter Data will be measured on a quarterly basis as “Pass” or “Fail” in accordance with QMED 2.0 requirements.
 1. No partial credit will be allowed.
2. Quarterly QMED 2.0 report cards are now posted publicly as of April 2026.
 1. Visibility and transparency to all.
3. Enforcement activities specific to QMED 2.0, including monetary sanctions will start July 1, 2027.
 1. Failing scores will result in financial penalties.





The Five Quality Measures

1. Uniqueness
2. Completeness
3. Accuracy
4. Reasonability
5. Timeliness





Quality Measures for Encounter Data (QMED) 2.0 - What's Changing?

On March 13, 2026, DHCS raised the bar for encounter data quality (APL 26-003). The data behind every claim you submit is now formally graded — and your claims are where that data starts.

GRADED

Pass / Fail

every quarter

DHCS scores the quality of encounter data across five measures — no partial credit.

PUBLIC

April 2026

report cards go public

Quarterly results are posted publicly — quality is now visible to everyone.

ENFORCED

July 2027

penalties begin

Monetary sanctions apply for failing scores. Acting now keeps us all ahead of it.

The good news: clean, complete, timely claims from your office are already most of the answer. This guide covers the five measures and the handful of habits that matter.





The Five Quality Measures - in Plain Language

Every measure traces back to something simple your office already controls:

UNIQUENESS

Bill once

≤ 0.5% duplicates

No duplicate claims or repeated service lines — resubmit only to correct.

COMPLETENESS

Name the clinician

≥ 90% with Type 1 NPI

Include the rendering clinician's individual (Type 1) NPI on every claim.

ACCURACY

Fix denials

99.5% corrected

Work denied claims to resolution — nearly every denial must be corrected.

REASONABILITY

Send clean claims

≤ 2% denied

Verify eligibility, codes, and authorizations before you submit.

TIMELINESS

Don't sit on claims

120 days · 15 days

Submit within 120 days of service; return corrections within 15 days.

One habit beats them all: submit complete claims within 30 days of the date of service. Early, clean claims give everyone time to fix issues long before any deadline.

You don't need to memorize the measure codes — that's our job. These five habits are the whole story.





What Changed from QMED 1.0

Same goal — quality data — but the rules now have teeth. Five shifts worth knowing:

What	Before (QMED 1.0)	Now (QMED 2.0)
Scoring	Tiered ratings	Pass / Fail each quarter
Visibility	Internal DHCS reports only	Public quarterly report cards (from Apr 2026)
Penalties	None tied to results	Monetary sanctions begin July 1, 2027
Duplicates	Loosely monitored ($\leq 7\%$)	Now scored: $\leq 0.5\%$ encounters · strict line limits
Deadlines	Timeliness expected, no hard number	90% of encounters within 120 days of service

What it means for your office: the same clean-claim habits you already know — submitted promptly, billed once, with the rendering clinician's NPI — now directly protect a public scorecard we share.



Top 5 Things Your Office Can Do

1

Submit claims within 30 days of the date of service

Well ahead of the 120-day limit — and it speeds up your payment too.

2

Include the rendering clinician's Type 1 (individual) NPI

On every claim line — group NPIs alone don't count toward the measure.

3

Bill once — don't resubmit unless correcting or asked

Duplicates are now a scored measure; extra copies hurt, not help.

4

Respond to denials and correction requests within 15 days

Fast turnaround keeps denials from becoming compliance findings.

5

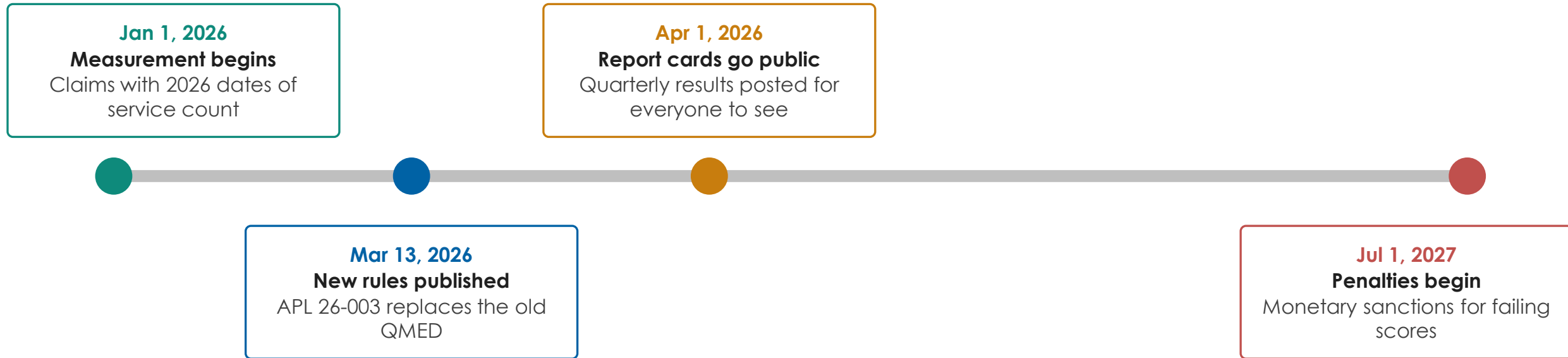
Use electronic claims (EDI) instead of paper

EDI claims arrive in days, not weeks — paper is the slowest route we see.



Key Dates to Know

We are already inside the measurement window — every claim you submit today counts.



Where we are today: Two quarters of scores are already in. We have a good window to build the habits shared in this presentation before penalties begin.



You're Not Doing This Alone

Health Plan is investing in the tools and touchpoints to keep this easy:

Ongoing Monitoring

1. Standing internal Encounter Data Committee monitors measures and flags issues monthly.
2. Provider Services informs providers of needed corrections.
3. Providers remediate errors and submit corrected claims.

Progress Reports

- Six-month progress report on 1/1/2027
- Annual report on 7/1/2027

Need Help?

1. Available resources
<https://www.dhcs.ca.gov/dhcs-encounter-data-landing-page/>
2. Still have questions, contact Provider Services
providerservices@hpsj.com

Thank you

www.hpsj-mvhp.org · 1-888-936-PLAN (7526)

