2026

Covered CA Quality Transformation Program (for PCPs)

Program Technical Guide

IEHP Covered

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PROGRAM OVERVIEW

This program guide provides an overview of the 2026 Covered CA (CCA) Quality Transformation Program (QTP) for IEHP Direct Primary Care Physicians (PCPs). The IEHP Covered CA Quality Transformation Program (QTP) for PCPs is designed to support the quality of health care for IEHPs Covered CA Members. The Covered CA Quality Transformation Program (QTP) aligns with the CCA Quality Exhibit IEHP Covered CA IEHP Direct PCPs contract requirements.

If you would like more information about IEHP's Covered CA Quality Transformation Program (QTP) or best practices to help improve quality scores and outcomes, visit our Secure Provider Portal at ***www.iehp.org***, email the Quality Team at ***QualityPrograms@iehp.org*** or call the IEHP Provider Relations Team at (909) 890-2054.

Eligibility

To be eligible for enhanced quality payments in the 2026 Covered CA Quality Transformation Program (QTP), PCPs must meet the following criteria:

- IEHP Direct Covered CA Primary Care Physicians (PCPs) who have a CCA Quality Exhibit IEHP Covered CA IEHP Direct PCP contract are eligible to participate in the Covered CA Quality Transformation Program (QTP).
- Have at least 20 Members in the denominator as of December 2026 for each quality measure to qualify for scoring.
- Have at least three quality measures that meet minimum denominator requirements in order for a CCA Star Rating score to be calculated.

☑ Minimum Data Requirements

Claims Data

Claims data is foundational to performance measurement and is essential in the 2026 Covered CA Quality Transformation Program. Complete, timely and accurate claims data should be submitted through normal reporting channels for all services rendered to IEHP Members. Please use the appropriate codes listed in Appendix 2 to meet measure requirements.

Lab Results

Data from lab results data is also foundational to Program performance measurement. Providers should ensure they submit complete lab results data for services rendered to IEHP Members. Work with IEHP to ensure you are using the appropriate lab vendors for IEHP Members.

Lab results that are performed in the office (e.g., point of care HbA1c testing, urine tests, etc.) should be coded and submitted through your encounter data.

Immunizations

To maximize performance in immunization-based measures, **IEHP requires all Providers to report all immunizations via the California Immunization Registry (CAIR2)**. For more information on how to register for CAIR2, please visit *http://cairweb.org/*. IEHP works closely with CAIR to ensure data sharing to support the Covered CA Quality Transformation program.

☑ Provider Research Inquiries

All Provider research inquiries, related to the data collected to measure program metrics, must be submitted in an excel worksheet. The following information must be included in the research inquiry to support the description of the dispute: Provider Name, Provider NPI, Member Name, Member ID, Measure Name, DOS, Procedure Code/ICD-10 code, and any other information that would be helpful to research the inquiry.

Program Terms and Conditions

- Good Standing: 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 Sections 810, et seq.) 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.
- Criteria for calculating Provider Star Rating are subject to change at any time, with or without notice, at IEHP's sole discretion.
- In consideration of IEHP's offering of the IEHP Covered CA Quality Transformation Program (QTP), participants agree to fully and forever release and discharge IEHP from any and all claims, demands, causes of action, and suits, of any nature, pertaining to or arising from the offering by IEHP of the IEHP Covered CA Quality Transformation Program (QTP).
- The determination of IEHP regarding performance scoring and Quality Performance Adjustments under the IEHP Covered CA Quality Transformation Program (QTP) is final.
- As a condition of receiving payment under the IEHP Covered CA Quality Transformation Program (QTP), Providers must be active and contracted with IEHP and have active assigned Members at the time of payment.
- Providers will not charge IEHP for medical records for HEDIS, Risk Adjustment, and other health plan operational activities.

Financial Overview: Quality Adjustment

Providers are eligible to receive a quality adjustment that will be based on the Provider's quality performance in the measurement year (2026). This quality adjustment may be an increase, or reduction, in the Providers IEHP base fee schedule rate. Refer to your CCA PCP agreement, Quality Exhibit for details.

Performance Measures

Appendix 1 provides a list of the 8 measures in the 2026 Covered CA Quality Transformation Core Program (QTP) and includes thresholds and benchmarks associated with respective Tier Goals.

Measures included in this program use standard Healthcare Effectiveness Data and Information Set (HEDIS®) process and outcomes measures that are based on the specifications published by the National Committee for Quality Assurance (NCQA). Non-HEDIS® measures that are included in the program come from the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Quality Program.

Program Measures:

- Annual Wellness Visit
- Child and Adolescent Well-Care Visits
- Chlamydia Screening
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Depression Screening and Follow-Up for Adolescents and Adults
- Glycemic Status Assessment for Patients with Diabetes
- Initial Health Appointment

Scoring Methodology

In this third year of the Covered CA Quality Transformation Program, Provider performance will be assessed based on performance improvement in the current measurement year (2026). Quality improvement adjustments in this program will be determined by the Providers performance in the program metrics being assessed. The measurement performance will begin once the IEHP Covered CA Member assignment begins with a Provider. The performance in this program will determine the "Quality Adjustment" rate that may impact the Provider's CCA Exhibit base rate, starting July 2027. The 2026 measurement year will assess performance within the period of January 1 – December 31, 2026.

NOTE: The Providers CCA Exhibit base rate will reset each measurement year back to the original base rate.

Year-Over-Year Improvement

The current measurement year (2026) performance baseline will be set from the final performance in the prior measurement year (2025). This program is designed to focus on value-based care where Provider reimbursement is directly tied to the quality of care provided to IEHP Members. There will be improvement factors that will take place starting in measurement year 2026, and continuing year-over-year, in the Covered CA Quality Transformation Program (QTP).

Performance Methodology

Calculating the Star Score

Provider performance for each measure will be given a star value (i.e., a measure score). Measure scores are applied based on star threshold cut points that are assigned per measure (see Appendix 1 for star threshold cut points).

The following formula will be used to calculate the overall Star Rating Score:
Star Rating Score = Sum (measure star rating * measure weight) / Sum of measure weights

The Star Rating will follow Table 1 below:

TABLE 1. COVERED CA QUALITY TRANSFORMATION PROGRAM (QTP) – STAR RATING:	
Initial Star Rating	**Overall Star Rating**
≥ 0.750000 and < 1.750000	1.0 Stars
≥ 1.750000 and < 2.750000	2.0 Stars
≥ 2.750000 and < 3.750000	3.0 Stars
≥ 3.750000 and < 4.750000	4.0 Stars
≥ 4.750000 and ≤ 5.000000	5.0 Stars

Calculating the Quality Adjustment

There will be **two** adjustments calculated for the 2026 performance year:

1) Quality Performance Adjustment
2) Quality Improvement Adjustment

The Quality Performance Adjustment and Quality Improvement Adjustment will both be used to determine the Providers overall Final PCP Quality Adjustment Amount (Providers CCA rate that will begin July following the measurement year through the next 12 months).

Quality Performance Adjustment

The Quality Performance Adjustment will be the first adjustment calculated for the current measurement year (2026) performance. The Quality Performance Adjustment will determine if there is a rate change made to the Provider's base CCA contractual rate.

The following method will be used to calculate the **Quality Performance Adjustment:**

Step 1: Determine current measurement year (2026) star rating (see Calculating the Star Score methodology).

Step 2: Determine Provider current measurement year (2026) Composite Quality Score (see Table 2: Provider Composite Quality Score & Associated Quality Performance Adjustment Overview).

Step 3: Determine Quality Performance Adjustment Amount based on current measurement year (2026) Provider Composite Quality Score (see Table 2: Provider Composite Quality Score & Associated Quality Performance Adjustment Overview).

TABLE 2. PROVIDER COMPOSITE QUALITY SCORE & ASSOCIATED QUALITY PERFORMANCE ADJUSTMENT OVERVIEW	
Provider Composite Quality Score	**Quality Performance Adjustment Amount**
5 Star Rating: Performance at the 90th percentile or higher	20% increase in base rate
4 Star Rating: Performance between the 66th percentile and 89th percentile	10% increase in base rate
3 Star Rating: Performance between the 33rd percentile and the 65th percentile	No change in base rate
2 Star Rating: Performance between the 10th percentile and 32nd percentile	5% reduction in base rate
1 Star Rating: Performance below the 10th percentile	10% reduction in base rate

Step 4: Calculate the Initial PCP Quality Adjustment Amount:

Initial PCP Quality Adjustment Amount = PCP base CCA rate + current measurement year (2026) Quality Performance Adjustment Amount.

Quality Improvement Adjustment

The Quality Improvement Adjustment will be the second adjustment calculated for the current measurement year (2026). The Quality Improvement Adjustment will determine if there is a second rate change made to the Provider's CCA contractual rate, based on the Quality Performance Adjustment for the measurement year (2026). The Quality Performance Adjustment rate change will be made to the Provider's CCA contractual rate starting July 2027 and continuing through June 2028.

NOTE: First-year CCA Providers will have a Quality Performance Adjustment only, with no Quality Improvement Adjustment applied.

The following method will be used to calculate the **Quality Improvement Adjustment:**

Step 1: Determine current measurement year (2026) star rating (see Calculating the Star Score methodology).

Step 2: Determine prior measurement year (2025) star rating.

Step 3: Calculate the improvement between current measurement year (2026) and prior measurement year (2025) star ratings.

Step 4: Determine Provider Improvement Composite Quality Score based on current measurement year (2026) to prior measurement year (2025) star score comparison.

Step 5: Use the Provider current measurement year (2026) Provider Improvement Composite Quality Score to indicate the Quality Improvement Adjustment (see Table 3).

TABLE 3. PROVIDER COMPOSITE QUALITY SCORE & ASSOCIATED QUALITY IMPROVEMENT ADJUSTMENT	
Provider Improvement Composite Quality Score	**Quality Improvement Adjustment**
Improved by 3 stars	+7.5%
Improved by 2 stars	+5%
Improved by 1 star	+2.5%
No change in star rating	None
Any decline in star rating	None

Step 6: Calculate the Final PCP Quality Adjustment Amount:

Final PCP Quality Adjustment Amount = Initial PCP Quality Adjustment Amount + current measurement year (2026) Quality Improvement Adjustment.

The Final PCP Quality Adjustment Amount will be applied as the Providers CCA contractual rate from July of the following year (2027) through June of the next year (2028).

Scoring Methodology Example:

Provider Example: Calculating Provider Final PCP Quality Adjustment Amount

PROVIDER JOHN DOE 2026 QUALITY IMPROVEMENT ADJUSTMENT FACTORS	
PCP Base Rate	100%
2025 Star Rating	2 star
2026 Star Rating	4 star

Calculating 2026 Final PCP Quality Adjustment Amount:

The following method will be used to calculate the **Quality Performance Adjustment:**

Step 1: Determine current measurement year (2026) star rating: *Provider finished the current measurement year (2026) with a 4 star rating.*

Step 2: Determine Provider current measurement year (2026) Composite Quality Score (see Table 2: Provider Composite Quality Score & Associated Quality Performance Adjustment Overview): *Providers Composite Quality Score is at a 4 star rating: between the 66th and 89th percentile.*

Step 3: Determine Quality Performance Adjustment Amount based on current measurement year (2026) Provider Composite Quality Score (see Table 2: Provider Composite Quality Score & Associated Quality Performance Adjustment Overview): *Providers Composite Quality Score is between the 66th and 89th percentile and meets a Quality Performance Adjustment amount of 10%.*

TABLE 2. PROVIDER COMPOSITE QUALITY SCORE & ASSOCIATED QUALITY PERFORMANCE ADJUSTMENT OVERVIEW	
Provider Composite Quality Score	**Quality Performance Adjustment Amount**
5 Star Rating: Performance at the 90th percentile or higher	20% increase in base rate
4 Star Rating: Performance between the 66th percentile and 89th percentile	10% increase in base rate
3 Star Rating: Performance between the 33rd percentile and the 65th percentile	No change in base rate
2 Star Rating: Performance between the 10th percentile and 32nd percentile	5% reduction in base rate
1 Star Rating: Performance below the 10th percentile	10% reduction in base rate

Step 4: Calculate the Initial PCP Quality Adjustment Amount:

Initial PCP Quality Adjustment Amount = PCP Base CCA rate + current measurement year (2026) Quality Performance Adjustment Amount.

Initial PCP Quality Adjustment Amount = 100 % + 10% = 110% CCA rate

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The following method will be used to calculate the **Quality Improvement Adjustment:**

Step 1: Determine current measurement year (2026) star rating: *Provider finished the current measurement year (2026) with a 4 star rating.*

Step 2: Determine prior measurement year (2025) star rating: *Provider finished the prior measurement year (2025) with a 2 star rating.*

Step 3: Calculate the improvement between current measurement year (2026) and prior measurement year (2025) star ratings: *Provider finishing the current measurement year (2026) with a 4 star rating compared to the prior measurement year (2025) with a 2 star rating corresponds to a 2 star rating improvement.*

Step 4: Determine Provider Improvement Composite Quality Score based on current measurement year (2026) to prior measurement year (2025) star score comparison: *Provider finishing the current measurement year (2026) with a 4 star rating compared to the prior measurement year (2025) with a 2 star rating corresponds to a Provider Improvement Composite Quality Score of 2 star rating improvement.*

Step 5: Use the Provider current measurement year (2026) Provider Improvement Composite Quality Score to indicate the Quality Improvement Adjustment (see Table 3 below): *Provider finishing the current measurement year (2026) with a 4 star rating compared to the prior measurement year (2025) with a 2 star rating corresponds to a 2 star rating improvement. This will give an additional 5% Quality Improvement Adjustment.*

TABLE 3. PROVIDER COMPOSITE QUALITY SCORE & ASSOCIATED QUALITY IMPROVEMENT ADJUSTMENT	
Provider Improvement Composite Quality Score	**Quality Improvement Adjustment**
Improved by 3 stars	+7.5%
Improved by 2 stars	+5%
Improved by 1 star	+2.5%
No change in star rating	None
Any decline in star rating	None

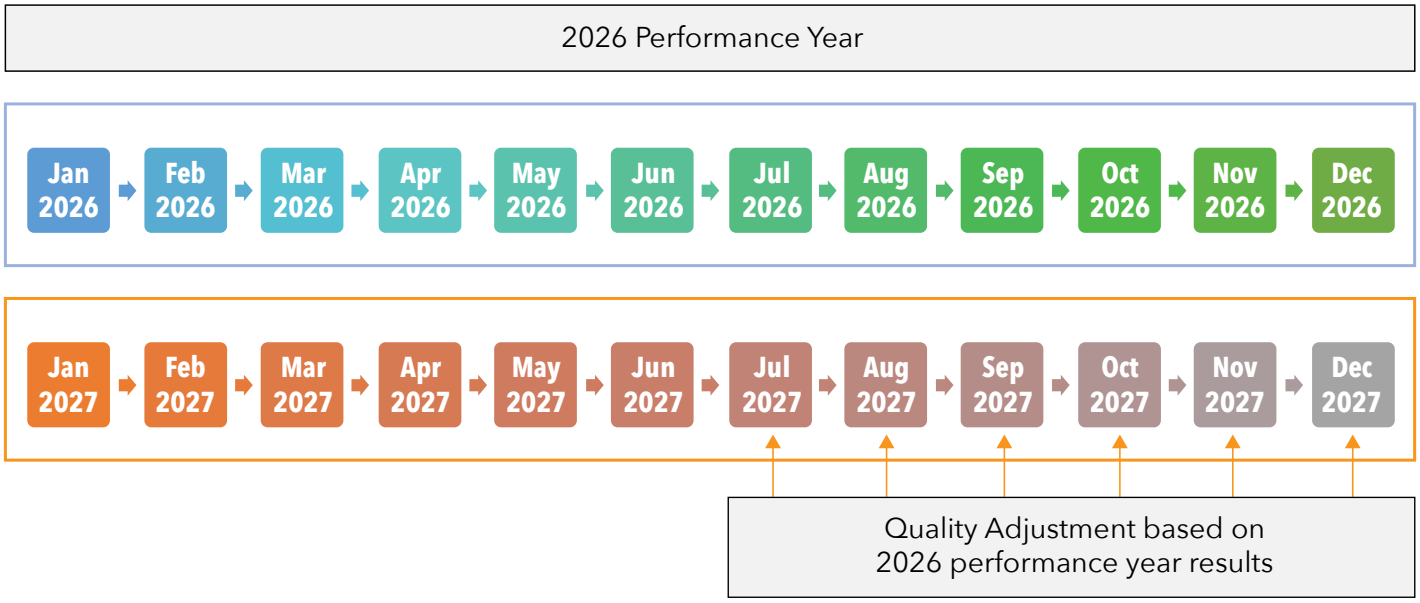
Step 6: Calculate the Final PCP Quality Adjustment Amount:

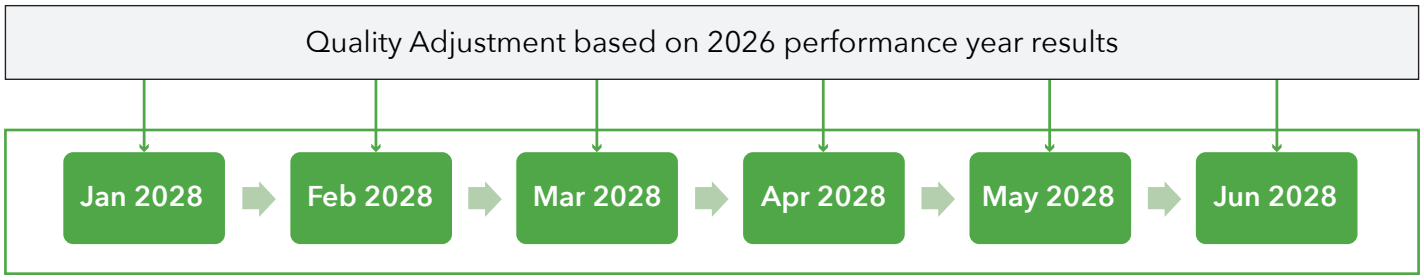
Final PCP Quality Adjustment Amount = Initial PCP Quality Adjustment Amount + current measurement year (2026) Quality Improvement Adjustment.

Final PCP Quality Adjustment Amount = 110% +5% = 115% CCA rate

The Final PCP Quality Adjustment Amount of 115% will be the new rate that will be applied as the Providers CCA contractual rate from July of the following year (2027) through June of the next year (2028).

Covered CA Quality Transformation Program Timeline:





Getting Help

Please direct questions and/or comments related to this program to the IEHP Provider Relations Team at (909) 890-2054 or IEHP's Quality Department at ***QualityPrograms@iehp.org***.

APPENDIX 1: *2026 PCP Covered CA Quality Transformation Program (QTP) Measures*

2026 COVERED CA QUALITY TRANSFORMATION PROGRAM (QTP) MEASURE LIST:								
Domain	**Measure Name**	**Population**	**Star 1 Rating**	**Star 2 Rating**	**Star 3 Rating**	**Star 4 Rating**	**Star 5 Rating**	**Measure Weight**
Clinical Quality	Annual Wellness Visit^^	Adults	<68%	68%	77%	84%	88%	3.0
Clinical Quality	Colorectal Cancer Screening*	Adults	Monitoring Only					NA
Clinical Quality	Controlling High Blood Pressure▪	Adults	<60%	60%	67%	74%	81%	3.0
Clinical Quality	Glycemic Status Assessment for Patients with Diabetes (GSD)♦	Adults	<56%	56%	79%	89%	93%	3.0
Behavioral Health Integration	Depression Screening and Follow-Up for Adolescents and Adults*	Adults and Adolescents	Monitoring Only					NA
Clinical Quality	Chlamydia Screening in Women▪	Women	<36%	36%	46%	55%	67%	1.0
Clinical Quality	Child and Adolescent Well-Care Visits▪	Children	<31%	31%	45%	58%	70%	1.0
Clinical Quality	Initial Health Appointment^	All	<2%	2%	37%	65%	90%	1.0

^^ *Star Rating set as published in the 2025 (MY 2024) Proxy Measure NCQA Health Plan Rating with a trend adjustment factor applied.*

▪ *Star Rating set as published in the 2025 (MY 2024) NCQA Exchange Quality Compass with a trend adjustment factor applied.*

♦ *Star Rating set as published in the MY 2026 CMS Benchmarks with a trend adjustment factor applied.*

^ *Star Rating set at the MY 2024 Medi-Cal Network Performance with a trend adjustment factor applied.*

* *Reporting Only Measure. Not eligible for incentive dollars.*

The goals in Appendix 1 may be adjusted once measurement year (2025) national benchmarks are available. The goals are based on a combination of national and network performance and may be adjusted higher or lower based on network trends.

CORE MEASURES

APPENDIX 2: *Measures Overview*

☑ Population: Adults

Annual Wellness Visit

Methodology: IEHP-Defined

Measure Description: The percentage of Members 18 years of age and older who received an annual wellness visit during the measurement year (2026). An annual wellness visit may include the following:

- Establish medical and family history
- Establish current Providers and prescriptions
- Obtain height, weight, blood pressure, BMI and other routine measurements
- Assess for Social Determinate of Health risk (optional)
- Review risk factors for depression
- Assess functional ability and patient safety
- Review and establish risk factors and treatment options
- Establish a written screening schedule for appropriate preventive services
- Provide personalized health advice
- Offer advance care planning services as needed

Denominator: Members 18 years of age and older.

- Anchor Date: December 31, 2026

Numerator: Members in the denominator who had an annual wellness visit during the measurement year (2026).

CODES TO IDENTIFY ANNUAL WELLNESS VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Annual Wellness Visit	HCPCS	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.
Annual Wellness Visit	HCPCS	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit.

CODES TO IDENTIFY ANNUAL WELLNESS VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Annual Wellness Visit	CPT	99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; (age 18-39 years)
Annual Wellness Visit	CPT	99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; (age 40-64 years)
Annual Wellness Visit	CPT	99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; (age 65 years and older)
Annual Wellness Visit	CPT	99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; (age 18-39 years)
Annual Wellness Visit	CPT	99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; (age 40-64 years)
Annual Wellness Visit	CPT	99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; (age 65 years and older)

Colorectal Cancer Screening (COL-E)

Methodology: HEDIS®

Measure Description: The percentage of Members who are 45-75 years of age who had an appropriate screening for colorectal cancer.

- Eligible population in this measure meets all of the following criteria:
  1. Members who are 46-75 years of age as of December 31 of the measurement year (2026).
  2. Continuous enrollment with IEHP during the measurement year (2026) and the year prior (2025) with no more than one gap in continuous enrollment with IEHP of up to 45 days during each year of the continuous enrollment period.

Denominator: Members who meet all the criteria for the eligible population.

- Anchor Date: December 31, 2026

Numerator: Members in the denominator who had one or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test during the measurement year (2026).
- Flexible sigmoidoscopy during the measurement year (2026) or four years prior to the measurement year (2022).
- Colonoscopy during the measurement year (2026) or the nine years prior to the measurement year (2017).
- CT colonography during the measurement year (2026) or the four years prior to the measurement year (2022).
- Stool DNA with FIT test during the measurement year (2026) or two years prior to the measurement year (2024).

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Colorectal Cancer Screening	CPT	0464U	Oncology (colorectal) screening, quantitative real-time target and signal amplification, methylated DNA markers, including LASS4, LRRC4 and PPP2R5C, a reference marker ZDHHC1, and a protein marker (fecal hemoglobin), utilizing stool, algorithm reported as a positive or negative result
Colorectal Cancer Screening	CPT	44388	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
Colorectal Cancer Screening	CPT	44389	Colonoscopy Through Stoma; With Biopsy, Single Or Multiple

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Colorectal Cancer Screening	CPT	44390	Colonoscopy Through Stoma; With Removal Of Foreign Body(s)
Colorectal Cancer Screening	CPT	44391	Colonoscopy Through Stoma; With Control Of Bleeding, Any Method
Colorectal Cancer Screening	CPT	44392	Colonoscopy Through Stoma; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Hot Biopsy Forcep
Colorectal Cancer Screening	CPT	44394	Colonoscopy Through Stoma; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Snare Technique
Colorectal Cancer Screening	CPT	44401	Colonoscopy Through Stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	44402	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	44403	Colonoscopy Through Stoma; With Endoscopic Mucosal Resection
Colorectal Cancer Screening	CPT	44404	Colonoscopy Through Stoma; With Directed Submucosal Injection(s), Any Substance
Colorectal Cancer Screening	CPT	44405	Colonoscopy through stoma; with transendoscopic balloon dilation
Colorectal Cancer Screening	CPT	44406	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
Colorectal Cancer Screening	CPT	44407	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
Colorectal Cancer Screening	CPT	44408	Colonoscopy through stoma; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
Colorectal Cancer Screening	CPT	45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
Colorectal Cancer Screening	CPT	45331	Sigmoidoscopy, Flexible; With Biopsy, Single Or Multiple
Colorectal Cancer Screening	CPT	45332	Sigmoidoscopy, Flexible; With Removal Of Foreign Body(s)
Colorectal Cancer Screening	CPT	45333	Sigmoidoscopy, Flexible; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Hot Biopsy Forceps
Colorectal Cancer Screening	CPT	45334	Sigmoidoscopy, Flexible; With Control Of Bleeding, Any Method
Colorectal Cancer Screening	CPT	45335	Sigmoidoscopy, Flexible; With Directed Submucosal Injection(s), Any Substance

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Colorectal Cancer Screening	CPT	45337	Sigmoidoscopy, flexible; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
Colorectal Cancer Screening	CPT	45338	Sigmoidoscopy, Flexible; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Snare Technique
Colorectal Cancer Screening	CPT	45340	Sigmoidoscopy, Flexible; With Transendoscopic Balloon Dilation
Colorectal Cancer Screening	CPT	45341	Sigmoidoscopy, Flexible; With Endoscopic Ultrasound Examination
Colorectal Cancer Screening	CPT	45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
Colorectal Cancer Screening	CPT	45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	45349	Sigmoidoscopy, Flexible; With Endoscopic Mucosal Resection
Colorectal Cancer Screening	CPT	45350	Sigmoidoscopy, Flexible; With Band Ligation(s) (e.g., Hemorrhoids)
Colorectal Cancer Screening	CPT	45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
Colorectal Cancer Screening	CPT	45379	Colonoscopy, Flexible; With Removal Of Foreign Body(s)
Colorectal Cancer Screening	CPT	45380	Colonoscopy, Flexible; With Biopsy, Single Or Multiple
Colorectal Cancer Screening	CPT	45381	Colonoscopy, Flexible; With Directed Submucosal Injection(s), Any Substance
Colorectal Cancer Screening	CPT	45382	Colonoscopy, Flexible; With Control Of Bleeding, Any Method
Colorectal Cancer Screening	CPT	45384	Colonoscopy, Flexible; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Hot Biopsy Forceps
Colorectal Cancer Screening	CPT	45385	Colonoscopy, Flexible; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Snare Technique
Colorectal Cancer Screening	CPT	45386	Colonoscopy, Flexible; With Transendoscopic Balloon Dilation
Colorectal Cancer Screening	CPT	45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	45390	Colonoscopy, Flexible; With Endoscopic Mucosal Resection

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Colorectal Cancer Screening	CPT	45391	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
Colorectal Cancer Screening	CPT	45392	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
Colorectal Cancer Screening	CPT	45393	Colonoscopy, flexible; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
Colorectal Cancer Screening	CPT	45398	Colonoscopy, Flexible; With Band Ligation(s) (e.g., Hemorrhoids)
Colorectal Cancer Screening	CPT	74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material
Colorectal Cancer Screening	CPT	74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed
Colorectal Cancer Screening	CPT	74263	Computed Tomographic (ct) Colonography, Screening, Including Image Postprocessing
Colorectal Cancer Screening	CPT	81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
Colorectal Cancer Screening	CPT	82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection)
Colorectal Cancer Screening	CPT	82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
Colorectal Cancer Screening	HCPCS	G0104	Colorectal Cancer Screening; Flexible Sigmoidoscopy
Colorectal Cancer Screening	HCPCS	G0105	Colorectal Cancer Screening; Colonoscopy On Individual At High Risk
Colorectal Cancer Screening	HCPCS	G0121	Colorectal Cancer Screening; Colonoscopy On Individual Not Meeting Criteria For High Risk
Colorectal Cancer Screening	HCPCS	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, one to three simultaneous determinations

**These are the codes that IEHP will use to determine the numerator compliance for the Colorectal Cancer Screening measure. These codes would be submitted by the testing Provider, not the PCP.*

Controlling High Blood Pressure (CBP)

Methodology: HEDIS®

Measure Description: The percentage of Members who are 18-85 years of age, with a diagnosis of hypertension (HTN), and whose blood pressure (BP) was controlled (<140/90 mm Hg) during the measurement year (2026).

- Eligible population in this measure meets all of the following criteria:
  1. Age 18-85 years of age as of December 31 of the measurement year (2026).
  2. Continuous enrollment with IEHP during the measurement year (2026) with no more than one gap in continuous enrollment with IEHP of up to 45 days during the measurement year (2026).
  3. Members who had at least two different visits with a hypertension diagnosis on or between January 1 of the year prior to the measurement year (2025) and June 30 of the measurement year (2026). Visit can be in any outpatient setting.

Denominator: All Members 18-85 years of age who meet all criteria for the eligible population.

- Anchor Date: December 31, 2026

Numerator: Members in the denominator who had a Blood Pressure reading that was adequately controlled <140/90 mm Hg. The latest Blood Pressure reading will be used to determine compliance. If there are multiple BPs on the same date of service, the lowest systolic and lowest diastolic Blood Pressure reading on that date will be used as a representative Blood Pressure reading. **Provider must bill one diastolic code and one systolic code.**

NOTE: The BP reading must be taken on or after the date of the second hypertension diagnosis.

CODES TO IDENTIFY BLOOD PRESSURE SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Blood Pressure Screening	CPT- CAT-II	3074F	Most recent systolic blood pressure less than 130 mm Hg (DM), (HTN, CKD, CAD)
Blood Pressure Screening	CPT- CAT-II	3075F	Most recent systolic blood pressure 130-139 mm Hg (DM) (HTN, CKD, CAD)
Blood Pressure Screening	CPT- CAT-II	3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM)
Blood Pressure Screening	CPT- CAT-II	3078F	Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM)
Blood Pressure Screening	CPT- CAT-II	3079F	Most recent diastolic blood pressure 80-89 mm Hg (HTN, CKD, CAD) (DM)
Blood Pressure Screening	CPT- CAT-II	3080F	Most recent diastolic blood pressure greater than or equal to 90 mm Hg (HTN, CKD, CAD) (DM)

Glycemic Status Assessment for Patients with Diabetes (GSD)

Methodology: HEDIS®

Measure Description: The percentage of Members 18-75 years of age and have a diagnosis of diabetes (type 1 and type 2) who had the following:

- Glycemic Status (<8.0%) – This includes diabetics whose most recent Glycemic Status (hemoglobin A1c or glucose management indicator [GMI]) during the measurement year (2026) has a value <8.0%.
    - The Member is not numerator compliant if the result for the most recent Glycemic Status Assessment is ≥8.0% or is missing a result, or if a Glycemic Status Assessment was not done during the measurement year (2026).
- The eligible population in this measure meets all of the following criteria:
    1. Members who are 18-75 years old as of December 31 of the measurement year (2026).
    2. Continuous enrollment with IEHP in the measurement year (2026) with no more than one gap of up to 45 days during the measurement year (2026).
    3. Members who meet any of the following criteria during the measurement year (2026) or the year prior to the measurement year (2025). Count services that occur over both years:
        - Members who had at least two diagnoses of diabetes on different days of service during the measurement year (2026) or the year prior to the measurement year (2025).
        - Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year (2026) or the year prior to the measurement year (2025) and have at least one diagnosis of diabetes during the measurement year (2026) or the year prior to the measurement year (2025).

CODES TO IDENTIFY GLYCEMIC STATUS TESTS:			
Service	**Code Type**	**Code**	**Code Description**
Glycemic Status Result	CPT	83037*	Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use
Glycemic Status Result	CPT-CAT-II	3044F	Most Recent Hemoglobin A1c (HbA1c) Level Less Than 7.0% (DM)
Glycemic Status Result	CPT-CAT-II	3046F	Most Recent Hemoglobin A1c Level Greater Than 9.0% (DM)
Glycemic Status Result	CPT-CAT-II	3051F	Most Recent Hemoglobin A1c (HbA1c) Level Greater Than Or Equal To 7.0% And Less Than 8.0%
Glycemic Status Result	CPT-CAT-II	3052F	Most Recent Hemoglobin A1c (HbA1c) Level Greater Than Or Equal To 8.0% And Less Than Or Equal To 9.0%

**Code is optional. If CPT code selected, must also be billed with corresponding CPT-CAT-II code for eligible measure compliance.*

- Members who meet any of the following criteria are excluded:
    1. Members in hospice.
    2. Members receiving palliative care.
    3. Members who expired at any time during the measurement year (2026).
    4. Members 66 years of age and older as of December 31 of measurement year (2026) with both frailty and advanced illness.

Denominator: Members 18-75 years of age who meet all the criteria for eligible population.

- Anchor Date: December 31, 2026

Numerator: Members in the denominator who had the most recent glycemic status test result of <8 during the measurement year (2026).

☑ Population: Adults and Adolescents

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Methodology: HEDIS®

Measure Description: The percentage of Members 12 years of age and older screened for clinical depression during the measurement year (2026) using a standardized instrument and, if screened positive, received follow-up care in the measurement year (2026). For this measure, two rates are calculated, and the average of both rates is used as the final score.

- The eligible population in this measure meets the following criteria:
  - Continuous enrollment with IEHP in the measurement year (2026) with no more than one gap of up to 45 days during the measurement year (2026).
- Members who meet any of the following criteria are excluded:
  - Members in hospice during the measurement year (2026).
  - Members who expire at any time during the measurement year (2026).
  - Members with depression that started during the prior measurement year (2025).
  - Members with a history of bipolar disorder at any time during the member's history through the end of the prior measurement year (2025).

Rate 1: *Depression Screening* - This measure assesses the percentage of Members aged 12 and older who were screened for clinical depression using an age-appropriate standardized tool during the measurement year (2026).

Denominator: All Members aged 12 years and older during the measurement year (2026). Member counted only once in the denominator.

Numerator: Members with a documented result for depression screening, using an age-appropriate standardized tool performed with a PCP during the measurement year (2026).

INSTRUMENTS FOR ADOLESCENTS (≤17 YEARS)	TOTAL SCORE LOINC CODES	POSITIVE FINDING
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	89204-2	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	71354-5	Total score ≥10
PROMIS Depression	71965-8	Total score ≥60

INSTRUMENTS FOR ADULTS (18+ YEARS)	TOTAL SCORE LOINC CODES	POSITIVE FINDING
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Duke Anxiety—Depression Scale (DUKE-AD)®	90853-3	Total score ≥30
Geriatric Depression Scale Short Form (GDS)	48545-8	Total score ≥5
Geriatric Depression Scale Long Form (GDS)	48544-1	Total score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
My Mood Monitor (M-3)®	71777-7	Total score ≥5
PROMIS Depression	71965-8	Total score ≥60
PROMIS Emotional Distress-Depression-Short Form	77861-3	Total score ≥60
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥31

Rate 2: *Follow-Up on Positive Screen* - This measure assesses the percentage of Members aged 12 and older who received follow-up care within 30 days of a documented positive depression screen finding during the measurement year (2026).

Denominator: All Members aged 12 years and older with a documented positive depression screen result during the measurement year (2026).

Numerator: Members who screened positive and received follow-up care on or up to 30 days after the date of the first positive screen (31 total days) in the measurement year (2026).

A follow-up on or up to 30 days after the first positive screen may include any of the following:

- An outpatient★, e-visit★, telephone★, or virtual check-in★, follow-up visit★ with a diagnosis of depression or other behavioral health condition◆.
- An encounter for depression case management● that documents assessment for symptoms■ or diagnosis of depression or other behavioral health conditions◆.
- An encounter for behavioral health▲, including assessment, therapy, collaborative care, or medication management.
- An encounter for exercise counseling diagnosis.
- A dispensed antidepressant medication*.

  OR

- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. *For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.*

Refer to the Depression Screening and Follow-Up for Adolescents and Adults (DSF-E): Positive Screen Follow-Up Code List on the IEHP website at: https://www.providerservices.iehp.org/en/programs-and-services/provider-incentive-programs/pay-for-performance-program#covered-california-quality-transformation-program. This list includes codes that identify follow-up care, for members who screen positive, on or up to 30 days after the date of the first positive screen. Please reference the superscripts in this list with the specifications described in the Follow-Up on Positive Screen numerator description.

☑ Population: Women

Chlamydia Screening (CHL)

Methodology: HEDIS®

Measure Description: The percentage of women 16-24 years of age who identified as sexually active and had at least one test for chlamydia during the measurement year (2026).

- The eligible population in the measure meets all of the following criteria:
  1. Women 16-24 years as of December 31 of the measurement year (2026).
  2. Continuous enrollment with IEHP during the measurement year (2026) with no more than one gap in enrollment of up to 45 days.
  3. There are two methods to identify sexually active women: claim/encounter data or pharmacy data.

CODES TO IDENTIFY SEXUALLY ACTIVE WOMEN:			
Service	**Code Type**	**Code**	**Code Description**
Sexually Active	CPT	86631	Antibody Chlamydia
Sexually Active	CPT	86632	Antibody Chlamydia Igm
Sexually Active	CPT	87110	Culture Chlamydia Any Source
Sexually Active	CPT	87270	Infectious Agent Antigen Detection By Immunofluorescent Technique Chlamydia Trachomatis
Sexually Active	CPT	87320	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Chlamydia trachomatis
Sexually Active	CPT	87490	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Chlamydia Trachomatis Direct Probe Technique
Sexually Active	CPT	87491	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Chlamydia Trachomatis Amplified Probe Technique
Sexually Active	CPT	87492	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Chlamydia Trachomatis Quantification
Sexually Active	CPT	87810	Infectious Agent Detection By Immunoassay With Direct Optical Observation Chlamydia Trachomatis

CONTRACEPTIVE MEDICATIONS	
Description	**Prescription**
Contraceptives	Desogestrel-ethinyl estradiol Dienogest-estradiol (multiphasic) Drospirenone-ethinyl estradiol Drospirenone-ethinyl estradiol-levomefolate (biphasic) Ethinyl estradiol-ethynodiol Ethinyl estradiol-etonogestrel Ethinyl estradiol-levonorgestrel Ethinyl estradiol-norelgestromin Ethinyl estradiol-norethindrone Ethinyl estradiol-norgestimate Ethinyl estradiol-norgestrel Etonogestrel Levonorgestrel Medroxyprogesterone Norethindrone
Diaphragm	Diaphragm
Spermicide	Nonxynol 9

CODES TO IDENTIFY CHLAMYDIA SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Chlamydia Screening	CPT	87110	Culture Chlamydia Any Source
Chlamydia Screening	CPT	87270	Infectious Agent Antigen Detection By Immunofluorescent Technique Chlamydia Trachomatis
Chlamydia Screening	CPT	87320	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Chlamydia trachomatis
Chlamydia Screening	CPT	87490	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Chlamydia Trachomatis Direct Probe Technique
Chlamydia Screening	CPT	87491	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Chlamydia Trachomatis Amplified Probe Technique
Chlamydia Screening	CPT	87492	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Chlamydia Trachomatis Quantification
Chlamydia Screening	CPT	87810	Infectious Agent Detection By Immunoassay With Direct Optical Observation Chlamydia Trachomatis

Denominator: Women 16-24 years of age who meet the criteria for eligible population.

- Anchor Date: December 31, 2026

Numerator: Women in the denominator who were tested at least once for chlamydia during the measurement year (2026).

☑ Population: Children

Child and Adolescent Well-Care Visits (WCV)

Methodology: HEDIS®

Measure Description: The percentage of Members ages 3-21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year (2026).

- Eligible population in this measure meets all of the following criteria:
    1. Ages 3-21 as of December 31 of the measurement year (2026).
    2. Continuous enrollment with IEHP throughout the measurement year (2026). No more than one gap in enrollment of up to 45 days during the measurement year (2026).

NOTE: Well-care visits done as telehealth visits will not be accepted for the Child and Adolescent Well-Care Visits measure.

CODES TO IDENTIFY WELL-CARE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Well-Care Visit	CPT	99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
Well-Care Visit	CPT	99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
Well-Care Visit	CPT	99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
Well-Care Visit	CPT	99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years

CODES TO IDENTIFY WELL-CARE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Well-Care Visit	CPT	99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
Well-Care Visit	CPT	99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
Well-Care Visit	CPT	99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
Well-Care Visit	CPT	99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
Well-Care Visit	HCPCS	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
Well-Care Visit	HCPCS	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit
Well-Care Visit	HCPCS	S0302	Completed early periodic screening diagnosis and treatment (EPSDT) service (list in addition to code for appropriate evaluation and management service)
Well-Care Visit	HCPCS	S0610	Annual gynecological examination, new patient
Well-Care Visit	HCPCS	S0612	Annual gynecological examination, established patient
Well-Care Visit	HCPCS	S0613	Annual gynecological examination; clinical breast examination without pelvic evaluation
Well-Care Visit	ICD-10	Z00.00	Encounter for general adult medical examination without abnormal findings
Well-Care Visit	ICD-10	Z00.01	Encounter for general adult medical examination with abnormal findings
Well-Care Visit	ICD-10	Z00.121	Encounter for routine child health examination with abnormal findings
Well-Care Visit	ICD-10	Z00.129	Encounter for routine child health examination without abnormal findings
Well-Care Visit	ICD-10	Z00.2	Encounter for examination for period of rapid growth in childhood
Well-Care Visit	ICD-10	Z00.3	Encounter for examination for adolescent development state
Well-Care Visit	ICD-10	Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
Well-Care Visit	ICD-10	Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Well-Care Visit	ICD-10	Z02.5	Encounter for examination for participation in sport

CODES TO IDENTIFY WELL-CARE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Well-Care Visit	ICD-10	Z02.84	Encounter for child welfare exam
Well-Care Visit	ICD-10	Z76. 1*	Encounter for health supervision and care of foundling
Well-Care Visit	ICD-10	Z76.2*	Encounter for health supervision and care of other healthy infant and child

**Code is optional. If code is selected for this measure, code must be billed as the Primary diagnosis on encounter for the encounter to process correctly.*

Denominator: The eligible population.

- Anchor Date December 31, 2026

Numerator: Members in the denominator who had one or more well-care visits with a PCP or an OB/GYN during the measurement year (2026).

☑ Population: All

Initial Health Appointment (IHA)

Methodology: IEHP-Defined Quality Measure

Measure Description: The IHA is a comprehensive assessment that is completed during the Member's initial encounter with a PCP, appropriate medical specialist, or Non-Physician Medical Provider, and it must be documented in the Member's medical record. The IHA enables the Member's PCP to assess and manage the acute, chronic and preventive health needs of the Member.

IEHP provides PCPs with a monthly detailed Member roster on the secure IEHP Provider Portal for all newly enrolled IEHP Members who are due for an IHA at 120 days of enrollment.

- The eligible population is newly assigned Members with an IEHP effective enrollment date of January 1, 2026 through August 31, 2026. The IHA must be provided within 120 days of enrollment (e.g., Member enrolled in August 2026 must be seen by December 2026 and PCP must submit encounter by January 2027).
- Newly enrolled IEHP CCA Members must complete a new IHA. Previous IHAs will not be accepted.

An IHA must include all of the following:

- A history of the Member's physical and mental health
- An identification of risks
- An assessment of need for preventive screens or services
- Health education
- The diagnosis and plan for treatment of any diseases

CODES TO IDENTIFY IHA VISITS:		
Code Type	**Code**	**Code Description**
CPT	96160	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.
CPT	96161	Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.
CPT	99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

CODES TO IDENTIFY IHA VISITS:		
Code Type	**Code**	**Code Description**
CPT	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
CPT	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
CPT	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
CPT	99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.
CPT	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
CPT	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
CPT	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
CPT	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
CPT	99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
CPT	99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
CPT	99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

CODES TO IDENTIFY IHA VISITS:		
Code Type	**Code**	**Code Description**
CPT	99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
CPT	99354	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient Evaluation and Management or psychotherapy service, except with office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215]).
CPT	99355	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; each additional 30 minutes (List separately in addition to code for prolonged service).
CPT	99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year).
CPT	99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years).
CPT	99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years).
CPT	99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years).
CPT	99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years.
CPT	99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years.
CPT	99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older.

CODES TO IDENTIFY IHA VISITS:		
Code Type	**Code**	**Code Description**
CPT	99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year).
CPT	99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years).
CPT	99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years).
CPT	99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years).
CPT	99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years.
CPT	99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years.
CPT	99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older.
CPT	99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.
CPT	99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes.
CPT	99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes.
CPT	99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes.
CPT	99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes.
CPT	99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes.

CODES TO IDENTIFY IHA VISITS:		
Code Type	**Code**	**Code Description**
CPT	99429	Unlisted Preven Meds Serv.
CPT	99444	Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous seven days, using the Internet or similar electronic communications network.
CPT	99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review.
CPT	99447	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review.
CPT	99448	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review.
CPT	99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review.
CPT	99450	Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with "chain of custody" protocols; and Completion of necessary documentation/certificates.
CPT	99455	Work-related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
CPT	99456	Work-related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
HCPCS	G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.

CODES TO IDENTIFY IHA VISITS:		
Code Type	**Code**	**Code Description**
HCPCS	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.
HCPCS	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit.
HCPCS	G0463	Hospital outpatient clinic visit for assessment and management of a patient.
HCPCS	T1015	Clinic visit/encounter, all-inclusive.
ICD10CM	Z00.00	Encounter for general adult medical examination without abnormal findings.
ICD10CM	Z00.01	Encounter for general adult medical examination with abnormal findings.
ICD10CM	Z00.121	Encounter for routine child health examination with abnormal findings.
ICD10CM	Z00.129	Encounter for routine child health examination without abnormal findings.
ICD10CM	Z02.5	Encounter for examination for participation in sport.

QUALITY IMPROVEMENT ACTIVITIES

Quality Improvement Activities

For the 2026 performance year, there will be two quality improvement activities providers will be required to complete as stated in the PCP Covered CA Quality Exhibit:

1) CCA Provider Directory
2) CCA Regional Quality Model Participation

CCA Provider Directory

Methodology: Department of Managed Health Care (DMHC)

Measure Description: Providers are required to submit IEHP Provider Directory demographics twice in the measurement year (2026), during the Provider Directory Verification process.

Provider elements required:

- **Race/Ethnicity** – This is the Provider's race and/or ethnicity. If a Provider is mixed race and identifies with more than one ethnicity, all should be listed on the verification form.
- **Language** Spoken by Staff and Provider – Languages spoken by the Providers, clinical staff, and/or administrative staff.

How the Provider will report or submit info: As part of IEHPs Provider Directory Verification process, Provider offices are asked to report/confirm their Provider demographics. Provider demographics are to be reported to IEHP via the fax number or email address based on Provider preference as part of the Provider Directory Verification process.

Submission Deadline: During the Provider Directory Verification process, Provider offices will have until December 31, 2026, to sign and attest to the verification form and return it to IEHP. Only responses during this window will be considered compliant for the 2026 Covered CA Quality Transformation Program (QTP).

CCA Regional Quality Model Participation

Methodology: IEHP – Defined Quality Improvement Activity

Measure Description: Inland Empire Health Plan (IEHP) has made quality improvement an essential focus to ensure IEHP Providers and Members reach optimal care and vibrant health. To assist in quality improvement efforts, IEHP has designed the IEHP Regional Quality Model (RQM) that has been created to engage in IEHP Members', Providers' and Community Partner's Quality challenges and needs by applying custom solutions. RQM is a quality improvement system that provides insights, solutions, and services through a regional framework. RQM aligns strategies, tactics, resources, data, metrics and people/teams to meet the unique needs of the communities, Providers and Members.

Goal: Providers, if selected, will be expected to participate in the RQM activities that include (but are not limited to):

- Take part in Quality Specialist Representative Support
- Work with IEHP Quality Engagement Specialists
- Be involved in Quality Coder coding and billing best practice recommendations

APPENDIX 3: *Provider Quality Resource*

This Provider Quality Resource is designed for IEHP Providers and their staff to assist in delivering high quality health care to their members. The goal is to provide IEHP Providers and their practice staff with various online resources that will help enhance their quality care in the following focus areas: Adult Preventive Health, Cardiovascular Disease Management, Child Preventive Health, Diabetes Management.

Our goal is to provide IEHP Providers and their practice staff with a comprehensive resource for enhancing quality in the discussed healthcare topics. Collaboration between IEHP and Providers has the potential to boost IEHP's quality rating, maximizing available funds for Provider incentive programs.

To request materials for your practice, please contact the IEHP Provider Call Center at (909) 890-2054, (866) 223-4347 or email ProviderServices@iehp.org.

We are dedicated to supporting our Providers and working together to improve the quality of care for our community. Together, we can "heal and inspire the human spirit." Thank you for all you do to provide quality health care to IEHP Members.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Adult Preventive Health	Member	Healthy Living My Best Self	An educational guide for Members on getting to and maintaining a healthy weight.
Adult Preventive Health	Member	BMI Calculator	Centers for Disease Control and Prevention (CDC) Body Mass Index Calculator.
Adult Preventive Health	Member	Health Screening Resources	IEHP Health Screening information and resources.
Adult Preventive Health	Member	Community Wellness Centers	Community Wellness Centers are places where you can take free exercise classes and/or health workshops.
Adult Preventive Health	Provider	Clinical Practice Guidelines	The tools provided on this page are meant to be used as resources to assist primary care providers in delivering care in accordance with IEHP standards.
Adult Preventive Health	Provider	Facility Site Review (FSR) Training	Multiple Facility Site Review and Medical Record Review resources for Providers, including DHCS standards and tools, plus IEHP's addendum tools.
Adult Preventive Health	Provider	Initial Health Appointment (IHA) Roster Information	The Department of Health Care Services (DHCS) requires that all newly enrolled Medi-Cal Members must receive an Initial Health Appointment (IHA).
Adult Preventive Health	Provider	Medicare Wellness Visits	Medicare Wellness Visit and Medicare Preventive Services guidelines from the Medicare Learning Network®

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Adult Preventive Health and Child Preventive Health	Member	Health Screenings Guide	IEHP Health Screening Guide provides information on all of the covered health screenings needed by Members at all stages of life.
Adult Preventive Health and Child Preventive Health	Provider	A and B Recommendations | United States Preventive Services Taskforce	A and B grade recommendations are services that the US Preventive Task Force most highly recommends implementing for preventive care
Cardiovascular Disease Management	Member	Healthy Heart	An educational guide for Members on understanding cardiovascular event risk and heart health.
Cardiovascular Disease Management	Member	Blood Pressure Brochure	A Member brochure focusing on high blood pressure management.
Cardiovascular Disease Management	Member	Blood Pressure Fact Sheets | American Heart Association	Fact Sheets on blood pressure from the American Heart Association.
Cardiovascular Disease Management	Provider	AAFPHypertension Guideline.pdf	Blood Pressure Targets in Adults With Hypertension: A Clinical Practice Guideline From the AAFP.
Cardiovascular Disease Management	Provider	Blood Pressure Targets in Adults with Hypertension	GuidelineCentral®
Cardiovascular Disease Management	Provider	AHA High Blood Pressure Toolkit (ascendeventmedia.com)	Hypertension Guideline Toolkit from the American Heart Association.
Cardiovascular Disease Management	Provider	The American Heart Association PREVENT Online Calculator	The American Heart Association PREVENT™ Online Calculator to calculate cardiovascular risk
Cardiovascular Disease and Diabetes Management	Provider	Comprehensive Medication Management Program	IEHP offers Medication Therapy Management to eligible Members. Services include medication therapy reviews, medication education, and disease management—including diabetes.
Cardiovascular Disease and Diabetes Management	Provider	Pharmacy No-Cost Prescription Delivery Benefit for IEHP Dual Choice, IEHP Covered, and IEHP Medi-Cal Members	SortPak, a mail order pharmacy which offers no-cost delivery and 100-day supplies for most medications.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Child Preventive Health	Member	Not Just Another Teen Health Guide	Booklet provides age-appropriate information on reproduction, birth control methods, and sexually transmitted infections.
Child Preventive Health	Member	Well Child Journey	Member handout detailing a child's wellness journey from newborn to young adulthood, including when immunizations and screenings are due.
Child Preventive Health	Member	AAP Schedule of Well-Child Care Visits	American Academy of Pediatrics Parenting Website with information on schedule of well-child visits and what to expect during each visit based on age.
Child Preventive Health	Provider	Bright Futures/AAP Periodicity Schedule	Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.
Child Preventive Health	Provider	Quality Performance Learning Guide	Provider and office staff resource with learning modules on measures including Child and Adolescent Well-Care Visits, Well Child Visits in the First 30 Months, Developmental Screening, Lead Screening, Topical Fluoride for Children, and Immunizations.
Child Preventive Health	Provider	Growth Charts	Growth chart forms for the following age ranges: 0-36 months and 2-20 years.
Child Preventive Health	Provider	Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Information on training and resources for Providers on Early and Periodic Screening, Diagnostic and Treatment (EPSDT).
Child Preventive Health	Provider	Early Start Program	California Early Start Program - refer infants and toddlers who have developmental delays or who are at risk of developmental disability.
Diabetes Management	Member	IEHP - Community Resources : Community Resource Centers :	IEHP Members can enroll in the Diabetes Self-Management workshop and Healthy Living classes at the Community Resource Centers
Diabetes Management	Member	Diabetes: What's Next?	Brochure on how to lead a healthy life for those diagnosed with diabetes.
Diabetes Management	Member	Staying Healthy With Diabetes	Booklet to help Members with diabetes self-management.
Diabetes Management	Member	Diabetes Prevention Program (DPP) - Live the Life You Love	Information about the online year-long lifestyle change program which pairs participants with a health coach to help set up and track health goals. Studies have shown that those who finish the program can lose weight and prevent Type 2 Diabetes.
Diabetes Management	Provider	Diabetes Standards of Care 2026	GuidelineCentral®
Diabetes Management	Provider	Diabetes Care Checklist_v5_EN	Diabetes Care Checklist

NOTES

IEHP

Covered

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