2025

GLOBAL QUALITY P4P
(FOR IPAs)

Pay for Performance (P4P) Program Technical Guide

IEHP
Inland Empire Health Plan

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PROGRAM OVERVIEW

This program guide provides an overview of the 2025 Global Quality Pay for Performance (GQ P4P) Program for Independent Physician Associations (IPAs). In this tenth year of the program, IEHP has made program enhancements based on feedback from Providers in an effort to continually improve effectiveness. The IEHP GQ P4P Program for IPAs is designed to reward IPAs for high performance and year-over-year improvement in key quality performance measures. This program guide is designed as an easy reference for IPAs and their staff to understand the GQ P4P Program.

This year's GQ P4P Program continues to provide financial rewards to Providers for improving health care quality across multiple domains and measures. The 2025 Global Quality P4P Program includes core measures, process measures and penalty "risk" measures.

To further prioritize the medical needs of IEHP Medi-Cal members, especially within preventive care and primary care services, IEHP will be aligning the 2025 GQ P4P IPA Program performance goals with Medi-Cal Managed Care Accountability Set (MCAS) goals established by the Department of Health Care Services (DHCS). MCAS is a set of performance measures that DHCS has chosen to be reported by Medi-Cal managed care Health Plans (MCPs). Achieving the minimum performance level (MPL), at the 50th percentile, or more, will assist in IEHPs commitment to ensuring IEHP Members achieve optimal care and vibrant health.

IEHP also encourages all IPAs to attend IEHP P4P meetings that are held throughout the year to support your efforts to maximize earnings in this program.

If you would like to get more information about IEHP's GQ P4P Program 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.

☑ What's New?

Two measures were Added

Core Measures

- Adult Hepatitis B Vaccine

Penalty Measures

- Medi-Cal Managed Care Accountability Set (MCAS) Performance

Two measures were Revised

Core Measures

- Adult Zoster Vaccine
- Adult Pneumococcal Vaccine

Fifteen measures were Retired

Core Measures

- Antidepressant Medication Management (AMM)
- Substance Use in Primary Care Adolescents
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- Screening for Clinical Depression in Primary Care
- Social Determinants of Health Identification Rate
- Social Determinants of Health Screening
- Social Need Screening and Intervention
- Substance Use Assessment in Primary Care
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents – Counseling for Physical Activity
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents – Counseling for Nutrition
- After Hours Availability- On- Call Physician Access
- After Hours Availability – Life-Threatening Emergency Calls
- Appointment Availability – Urgent
- Appointment Availability – Routine

Process Measures

- Provider Diversity Equity Inclusion Survey

☑ Eligibility and Participation

To be eligible for incentive payments in the 2025 GQ P4P Program, IPAs must meet the following criteria:

- Have at least 5,000 IEHP Medi-Cal Members assigned as of January 2025.
- Have at least 30 Members in the denominator as of December 2025 for each quality measure to qualify.
- Quality Score must be 1.0 or higher in order to qualify for incentive payments.
- Submit a GQ P4P Quality Work Plan to IEHP by April 28, 2025, in order to enroll in the program (see Work Plan details in Appendix 9).
- Meet minimum Encounter Data Gates in order to qualify for incentive payments.
- IPA must designate a Quality Team of two to four staff dedicated to quality improvement work for the IPA. Quality Team framework will require an attestation and submission of staffing plan by 7/1/2025.

☑ Minimum Data Requirements

Lab Results

Data from lab results is also foundational to Program performance scoring. Providers should ensure they submit complete lab results data for services rendered to IEHP Members. IPAs should work with their network Providers to ensure they are using the appropriate lab vendors for IEHP Members and submitting complete lab results data to IEHP.

Lab results that are performed in the office (e.g., point of care HbA1c testing, urine tests, etc.) should be coded and submitted through Providers' 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 GQ P4P program.

☑ Provider P4P Research Inquiries

All Provider research inquiries, related to the data collected to measure P4P 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.

Supplemental Data

What is Supplemental Data?

When services are not captured in traditional encounter data systems, other Supplemental Data sources may be used to collect information about services rendered to Members to support Quality Reporting.

When Supplemental Data may be needed

- For services that were provided prior to eligibility with IEHP
- When a Provider has "proof-of-service" for a noted gap in care (e.g., cervical cancer screening, immunizations rendered by another provider)
- When a Provider has "proof-of-service" for an eligible-population exclusion (e.g., total hysterectomy, bilateral mastectomy)

How to use Supplemental Data to support Global Quality P4P

Create an electronic log that includes the minimum required data elements. See Appendix 10 for file layout requirements. Below is a list of minimum data elements needed in a supplemental data log.

- Member ID
- Date of Service
- Provider Identification
- Provider Specialty
- Diagnosis Code(s) – if applicable
- Procedure Code(s)
- Lab Results – if applicable

Requirements for using Supplemental Data in Global Quality P4P Reporting

- The IPA must have clearly defined policies and procedures (in writing) that describe how Supplemental Data is collected, validated and used for P4P reporting
- Policies/procedures must be shared with IEHP and must be in place to validate quality / accuracy of Supplemental Data
- The IPA must collect "proof-of-service" documentation to confirm all services that are reported in the Supplemental Data log

- The IPA must receive approval from IEHP's Quality Team to use Supplemental Data in Global Quality Reporting (deadline for approval is October 31, 2025)
- The IPA must complete IPA data validation activities prior to submitting Supplemental Data to IEHP no later than November 30, 2025
- The IPA must submit an audit-ready Supplement Data log to IEHP via SFTP no later than December 20, 2025.
- The IPA must complete a P4P Roadmap no later than October 31, 2025
- Final data refreshes for pre-validated supplemental data (for remaining dates of service in December 2025) are due by January 31, 2026

Data Validation Requirements for Supplemental Data in Global Quality P4P Reporting

- To be counted in the final IPA Global Quality P4P rates, the Supplemental Data file must pass IEHP's independent HEDIS® audit process
- The IPA must present "proof-of-service" documents within required timeframes when requested by IEHP's auditors
- An auditor review will compare "proof-of-service" documents to submitted data
- Supplemental Data records must pass 100 percent validation to be included in the final P4P reporting

☑ 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.
- Participation in IEHP's GQ P4P Program, as well as acceptance of incentive payments, does not in any way modify or supersede any terms or conditions of any agreement between IEHP and Providers or IPAs, whether that agreement is entered into prior to or subsequent to the date of this communication.
- There is no guarantee of future funding for, or payment under, any IEHP Provider incentive program. The IEHP GQ 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 IEHP GQ P4P Program, 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 GQ P4P Program.

- The determination of IEHP regarding performance scoring and payments under the IEHP GQ P4P Program is final.
- As a condition of receiving payment under the IEHP GQ P4P Program, Providers and IPAs 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

Providers are eligible to receive financial rewards for performance excellence and for performance improvement. Financial rewards are based on a tiered system, providing increasing financial rewards as IPAs reach each level of higher performance. The 2025 GQ P4P Program incentive pool is $37.5 million for the IPA Program. Incentive dollars for the 2025 performance period will be distributed via a monthly Per Member Per Month (PMPM) Quality Payment beginning in July 2026 and continuing through June 2027. Based on IPA performance, payment methodologies may be adjusted to ensure that the 2025 program year costs do not exceed this $37.5 million pool for the IPA Program.

IPA Encounter Data Gates

IPA encounter data submissions must meet minimum adequacy requirements in order to receive GQ P4P Program incentive dollars. IPA encounter data performance is based on all professional encounters submitted by the IPA for services rendered during the measurement year (e.g., 2025 dates of service). IPA encounter data volume will be compared to established encounter data benchmarks for Seniors and Persons with Disabilities (SPD) and Non-SPD Members. IPA performance will be calculated against each IPA's proportion of SPD and Non-SPD Members.

Encounter data benchmarks have been established and correspond to an Encounter Data Gate, reflecting higher encounter data volumes. As IPAs reach higher levels of encounter data performance, they become eligible for a larger percentage of the total possible GQ P4P incentive. Encounter rates are expressed as the number of encounters per Member per year (PMPY). An encounter is defined as a unique visit per Member per Provider per day. The table below describes the Encounter Data Gates, performance levels, and their impact on IPA GQ P4P Program incentive payments.

PERCENT OF POSSIBLE INCENTIVE PAYMENT	ENCOUNTER DATA GATE	NON-SPD PMPY	SPD PMPY
50%	Gate 1	3.0	9.0
75%	Gate 2	4.0	11.0
100%	Gate 3	5.0	13.0

Encounter data must be submitted to IEHP in a timely way and must adhere to the reporting timeframes delineated in IEHP's Provider Policy and Procedure Manual - Policy MC_21A.

CORE MEASURES

Performance Measures

Appendix 1 provides a list of the 32 measures in the 2025 GQ P4P Core Program and includes the thresholds and benchmarks associated with respective tier goals. These measures are categorized into three domains: *Access, Clinical Quality, and Patient Experience.*

Most measures included in the *Clinical Quality Domain* primarily 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 and internally developed IEHP measures.

Clinical Quality Domain Measures:

- Asthma Medication Ratio
- Breast Cancer Screening
- Cervical Cancer Screening
- Child and Adolescent Well-Care Visits
- Childhood Immunization – Combo 10
- Chlamydia Screening
- Timeliness of Prenatal Care
- Postpartum Care
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Diabetes Care – Blood Pressure Control <140/90
- Glycemic Status Assessment for Patients with Diabetes
- Diabetes Care – Kidney Health Evaluation
- Developmental Screening
- Lead Screening for Children
- Adult Influenza Vaccine
- Adult Pneumococcal Vaccine
- Adult Td/Tdap Vaccine
- Adult Zoster Vaccine
- Adult Hepatitis B Vaccine
- Immunizations for Adolescents – Combo 2
- Initial Health Appointment
- Post Discharge Follow-Up
- Statin Therapy Received in Patients with Cardiovascular Disease and Diabetes
- Use of Imaging Studies for Low Back Pain
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - BMI
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the First 30 Months of Life

IEHP's HEDIS® measurement year 2025 data set and Managed Care Accountability Set (MCAS) will be used to evaluate Providers' year-end performance. These measure sets undergoes an independent audit review prior to rate finalization.

The Initial Health Appointment (IHA) measure follows IEHP's IHA internal compliance monitoring methodology and is not a HEDIS® measure.

The Post Discharge Follow-Up measure is an IEHP-defined measure developed to support transitions of care needs of IEHP Members.

Access Domain:

- Potentially Avoidable Emergency Department (ED) Visits

The Access measure follows the California Department of Healthcare Services (DHCS) methodology for determining Low-acuity non-emergent (LANE) visits in accordance with the New York University (NYU) research conducted on classifying emergency department utilization. (https://wagner.nyu.edu/community/faculty)

Patient Experience Domain Measures:

Patient Experience Domain measures include Member Satisfaction Survey (MSS) questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that is published by the Agency for Healthcare Research and Quality (AHRQ). IEHP conducts a Member Satisfaction Survey that is a modified CAHPS survey and is the sole data source used for this measure domain. The IEHP Member Satisfaction Survey is conducted between June and December of each year. Surveys received from the 2025 Member Satisfaction Survey will be used to calculate the Patient Experience Domain measures. Below are the three areas included in the Patient Experience Domain for the 2025 program.

- Access to Care Needed Right Away
- Coordination of Care
- Rating of Access to Routine Care

Scoring Methodology

Payments within the core program will be awarded to IPAs based on individual performance in reaching established Quality Goals (e.g., Tier Goals for each measure).

In the *Clinical Quality Domain,* HEDIS® measure results are based on each measure's total eligible population assigned to the IPA. The eligible population is defined as the set of Members that meet the denominator criteria specified in each measure by NCQA. Members in the eligible population are attributed to the assigned PCP on the anchor date of each measure, as defined within each measure. Members contribute to a IPA's measure denominator if continuous enrollment criteria are met at the health plan level. For each measure, the measure score reflects the proportion of the eligible population that complies with the numerator criteria. For measures that are based on the HEDIS methodology, IEHP will adhere to the most current HEDIS technical specifications (Volume 2) for determining both numerators and denominators.

In the Clinical Quality Domain, non-HEDIS measures include the Initial Health Appointment and the Post Discharge Follow-Up measure. Each measure was designed by IEHP using validated coding and technical specifications. The Initial Health Appointment Measure is based on DHCS requirements and includes new health plan Members who are assigned to the IPA during the measurement year and who remain enrolled with IEHP and the IPA by the age-appropriate enrollment period. The Post Discharge Follow-Up measure is described in detail in Appendix 2.

In the *Access Domain*, IEHP follows the California Department of Healthcare Services (DHCS) methodology for determining Low-acuity non-emergent (LANE) visits in accordance with the New York University (NYU) research conducted on classifying emergency department utilization. (https://wagner.nyu.edu/community/faculty)

In the *Patient Experience Domain*, monthly Member Satisfaction Survey (MSS) measures are based on Members who meet eligibility criteria to receive a mailed survey between June and December of the measurement year. Members eligible to receive a Member Satisfaction Survey must have been continuously enrolled with IEHP for at least six months in the measurement year (2025) and must have had an office visit in the prior six months, based on encounter data submitted to IEHP. Members who meet the survey eligibility criteria are randomly sampled to receive a survey. Survey measure results are attributed to the Member's assigned IPA based on the most recent encounter that qualified the Member for the survey. A Member is eligible to receive only one survey per calendar year.

Payment Methodology

IPA performance for each quality measure will be given a point value (i.e., a Quality Score). Points are assigned based on the Tier Goal achieved (i.e., Tier 1 = one point, Tier 2 = two points, Tier 3 = three points, Tier 4 = four points) for each measure.

IPAs who have at least three quality measures that meet the minimum denominator size (n = 30) will be considered for payment calculations. An overall weighted average of all eligible Quality Scores will determine the overall GQ Performance Score. Individual measure weights will be assigned as follows:

- Process measures (such as screenings) are given a weight of 1
- Patient experience measures are given a weight of 1.5
- Outcome and intermediate outcome measures (e.g., HbA1c or blood pressure control and childhood immunizations) are given a weight of 3 or 4

Please reference Appendix 1 for a list of individual measure weights for the 2025 GQP4P measure set.

The following formula will be used to calculate the overall **GQ Performance Score**:

GQ Performance Score (i.e. overall weighted average) = Sum (measure tier * measure weight) / Sum of measure weights

GQ P4P Program payments will be awarded according to the following formula:

([Global Quality Performance Score] x [# Medi-Cal Average Member Months] x [GQ P4P Multiplier] / [Total Medi-Cal Member Months]) + Process Measures - Penalty Measures = GQ P4P PMPM Bonus

The GQ P4P payment multiplier is subject to change based on Network performance and budget limits. The GQ P4P payment multiplier value displayed in the Interim Reports may not be the final value used in determining final Quality PMPM payment amounts.

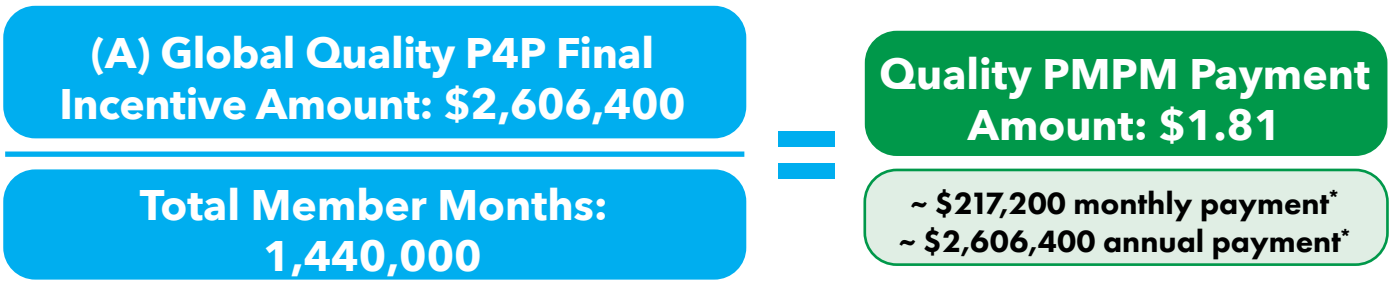
IPAs eligible for the 2025 Global Quality P4P Quality PMPM payment have the opportunity to earn up to the maximum Quality Score and Quality PMPM amount listed below:

ELIGIBLE ENTITY	MAXIMUM QUALITY SCORE	MAXIMUM QUALITY PMPM
IPA	3.73	$5.87

IPA PMPM Quality Payment Methodology

From July 2026 – June 2027, IPAs will receive a monthly Quality PMPM (per member per month) payment based on their 2025 GQ P4P performance using the following formula:

IPA payment example: *IPA with monthly average of 120,000 Members (1,440,000 Member Months), 2.0 GQ Quality Score and Encounter Data Gate 3 met*



**Assuming stable membership volume and there is no additional incentive for process measures, and no PCP penalty to be deducted from the Quality PMPM bonus.*

Note: Members with and Other Health Coverage will be removed from the measure denominators before the final payment calculation.

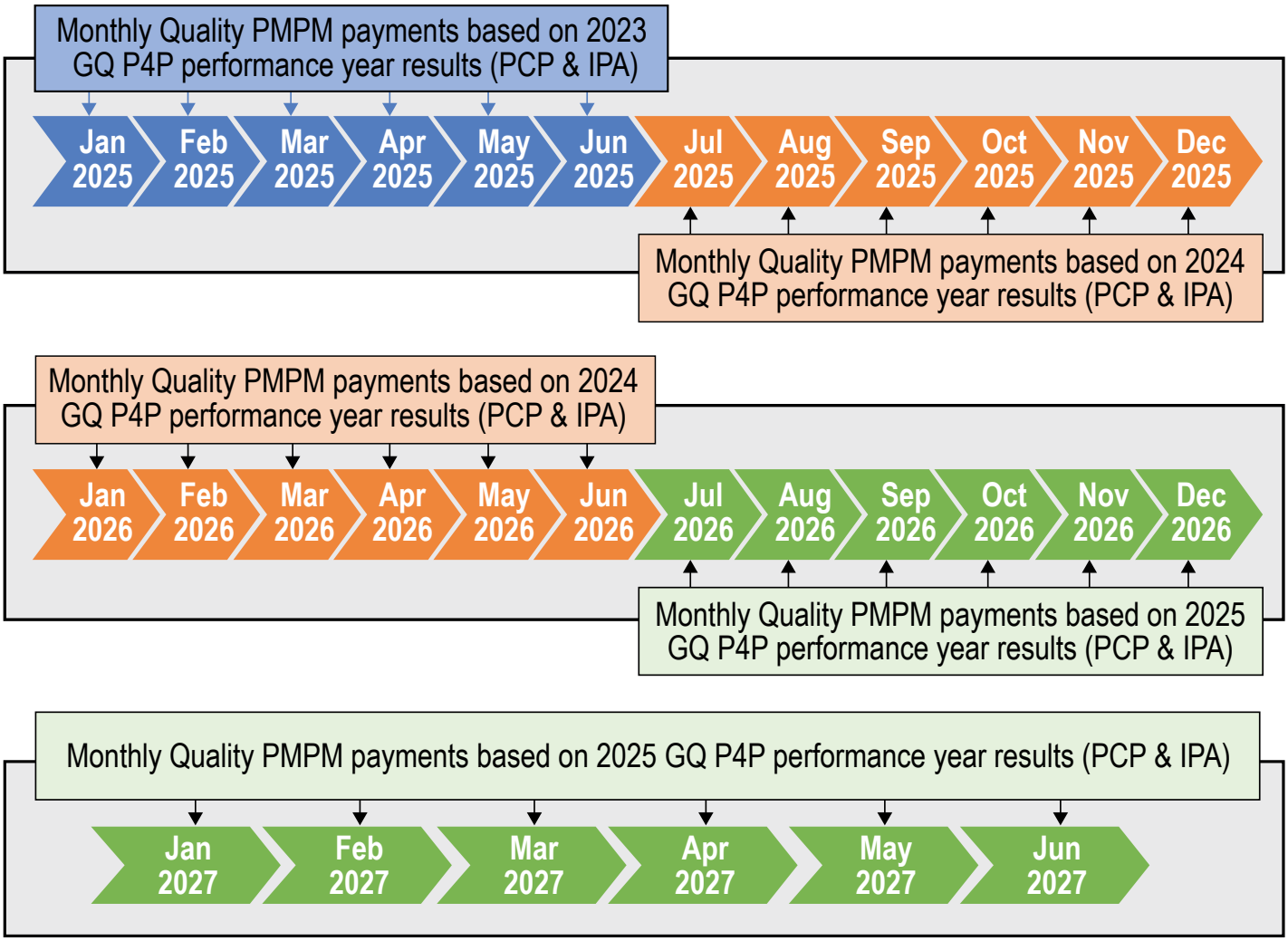
Reporting Timeline

Below is a table describing the flow of encounter data to IEHP in support of the GQ P4P Program reporting.

P4P ENCOUNTER DATA REPORTING TIMELINE:					
Month of Service	**Provider Encounters Due to IPA**	**IPA Encounters Due to IEHP**	**P4P Data Freeze**	**Dates of Service Assessed**	**Rosters Updated**
January 2025	2/1/2025	2/15/2025	2/15/2025	January 2025	3/10/2025
January 2025	2/1/2025	3/1/2025	3/1/2025	January 2025	3/25/2025
January 2025	2/1/2025	3/15/2025	3/15/2025	January 2025	4/10/2025
January 2025	2/1/2025	4/1/2025	4/1/2025	January 2025	4/25/2025
January 2025	2/1/2025	4/15/2025	4/15/2025	January 2025	5/10/2025
January 2025	2/1/2025	5/1/2025	5/1/2025	January 2025	5/25/2025
January 2025	2/15/2025	5/15/2025	5/15/2025	January 2025	6/10/2025
February 2025	3/1/2025	6/1/2025	6/1/2025	January - February 2025	6/25/2025
February 2025	3/15/2025	6/15/2025	6/15/2025	January - February 2025	7/10/2025
March 2025	4/1/2025	7/1/2026	7/1/2026	January - March 2025	7/25/2025
March 2025	4/15/2025	7/15/2025	7/15/2025	January - March 2025	8/10/2025
April 2025	5/1/2025	8/1/2025	8/1/2025	January - April 2025	8/25/2025
April 2025	5/15/2025	8/15/2025	8/15/2025	January - April 2025	9/10/2025
May 2025	6/1/2025	9/1/2025	9/1/2025	January - May 2025	9/25/2025
May 2025	6/15/2025	9/15/2025	9/15/2025	January - May 2025	10/10/2025
June 2025	7/1/2025	10/1/2025	10/1/2025	January - June 2025	10/25/2025
June 2025	7/15/2025	10/15/2025	10/15/2025	January - June 2025	11/10/2025
July 2025	8/1/2025	11/1/2025	11/1/2025	January - July 2025	11/25/2025
July 2025	8/15/2025	11/15/2025	11/15/2025	January - July 2025	12/10/2025
August 2025	9/1/2025	12/1/2025	12/1/2025	January - August 2025	12/25/2025
August 2025	9/15/2025	12/15/2025	12/15/2025	January - August 2025	1/10/2026
September 2025	10/1/2025	1/1/2026	1/1/2026	January - September 2025	1/25/2026
September 2025	10/15/2025	1/15/2026	1/15/2026	January - September 2025	2/10/2026
October 2025	11/1/2025	2/1/2026	2/1/2026	January - October 2025	2/25/2026
October 2025	11/15/2025	2/15/2026	2/15/2026	January - October 2025	3/10/2026
November 2025	12/1/2025	3/1/2026	3/1/2026	January - November 2025	3/25/2026
November 2025	12/15/2025	3/15/2026	3/15/2026	January - November 2025	4/10/2026
December 2025	1/1/2026	4/1/2026	4/1/2026	January - December 2025	4/25/2026
December 2025	1/15/2026	4/15/2026	4/15/2026	January - December 2025	5/10/2026
December 2025	2/1/2026	5/1/2026	5/1/2026	January - December 2025	5/25/2026

This timeline depicts the latest reporting dates based on IEHP's policies and procedures. However, Providers and IPAs are encouraged to report their encounter data as soon as possible to IEHP. All encounters received by IEHP are considered when calculating updated reports and rosters including those encounters that are reported earlier than the encounter data due date.

Quality Incentive Payout Timeline: Provider Communication Timeline



Getting Help

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

APPENDIX 1: *2025 IPA Global Quality P4P Program Measures*

2025 GQ P4P PROGRAM MEASURE LIST:							
Domain	**Measure Name**	**Population**	**Tier 1**	**Tier 2**	**Tier 3 [1]**	**Tier 4 [2]**	**Measure Weight**
Clinical Quality	Asthma Medication Ratio	Adult	Improvement demonstrated by meeting the following 2 conditions: 10% reduction in non-compliance **AND Improvement of at least 2% points**	**If baseline is below 50th percentile:** 20% reduction in non-compliance **AND** must meet the 50th percentile **If baseline is at or above 50th percentile: Improvement of at least 2% points**	74%	79%	3.0
Clinical Quality	Colorectal Cancer Screening	Adult			46%	51%	1.0
Clinical Quality	Controlling High Blood Pressure	Adult			71%	75%	4.0
Clinical Quality	Diabetes Care- Blood Pressure Control <140/90	Adult			76%	79%	3.0
Clinical Quality	Glycemic Status Assessment for Patients with Diabetes	Adult			63%	66%	4.0
Clinical Quality	Diabetes Care- Kidney Health Evaluation	Adult			47%	52%	1.0
Clinical Quality	Adult Influenza Vaccine	Adult			22%	28%	1.0
Clinical Quality	Adult Pneumococcal Vaccine	Adult			60%	70%	1.0
Clinical Quality	Adult Td/Tdap Vaccine	Adult			52%	60%	1.0
Clinical Quality	Adult Zoster Vaccine	Adult			18%	23%	1.0
Clinical Quality	Post Discharge Follow-Up	Adult			74%	89%	1.0
Clinical Quality	Statin Therapy Received for Patients with Cardiovascular Disease and Diabetes[3]	Adult			78%	81%	1.0
Clinical Quality	Adult Hepatitis B Vaccine[5]	Adult	Monitoring Only				NA
Clinical Quality	Use of Imaging Studies for Low Back Pain[4]	Adult and Adolescent	Monitoring Only				NA
Clinical Quality	Breast Cancer Screening	Women	Improvement demonstrated by meeting the following 2 conditions: 10% reduction in non-compliance **AND Improvement of at least 2% points**	**If baseline is below 50th percentile:** 20% reduction in non-compliance **AND** must meet the 50th percentile **If baseline is at or above 50th percentile: Improvement of at least 2% points**	62%	65%	1.0
Clinical Quality	Cervical Cancer Screening	Women			64%	69%	1.0
Clinical Quality	Chlamydia Screening	Women			66%	71%	1.0
Clinical Quality	Timeliness of Prenatal Care	Women			91%	94%	1.0
Clinical Quality	Postpartum Care	Women			85%	89%	1.0
Clinical Quality	Child and Adolescent Well- Care Visits	Child			60%	67%	1.0
Clinical Quality	Childhood Immunizations - Combo 10[†]	Child			37%	44%	4.0
Clinical Quality	Developmental Screening	Child			48%	55%	1.0
Clinical Quality	Immunizations for Adolescents - Combo 2	Child			44%	51%	4.0
Clinical Quality	Lead Screening for Children	Child			73%	82%	1.0
Clinical Quality	Well-Child Visits First 15 Months of Life	Child			67%	72%	1.0
Clinical Quality	Well-Child Visits First 30 Months of Life	Child			75%	82%	1.0
Clinical Quality	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - BMI	Child			90%	93%	1.0
Clinical Quality	Initial Health Appointment	All			79%	87%	1.0

2025 GQ P4P PROGRAM MEASURE LIST:							
Domain	**Measure Name**	**Population**	**Tier 1**	**Tier 2**	**Tier 3 [1]**	**Tier 4 [2]**	**Measure Weight**
Access	Potentially Avoidable ED Visits	All	<5.0%	NA	NA	NA	3.0
Patient Experience	Access to Care Needed Right Away	All	86%*	87%**	90%***	NA	1.5
Patient Experience	Coordination of Care	All	87%*	89%**	93%***	NA	1.5
Patient Experience	Rating of Access to Routine Care	All	82%*	84%**	88%***	NA	1.5

** Tier 1 goals set at the 50th percentile as published in the 2024 (MY 2023) NCQA Quality Compass with a trend adjustment factor applied.*
*** Tier 2 goals set at the 66th percentile as published in the 2024 (MY 2023) NCQA Quality Compass with a trend adjustment factor applied.*
**** Tier 3 goals set at the 90th percentile as published in the 2024 (MY 2023) NCQA Quality Compass with a trend adjustment factor applied.*
[1] Tier 3 goals set at the 75th percentile as published in the 2024 (MY 2023) NCQA Quality Compass with a trend adjustment factor applied.
[2] Tier 4 goals set at the 90th percentile as published in the 2024 (MY 2023) NCQA Quality Compass with a trend adjustment factor applied.
[3] The Statin Therapy Received for Patients with Cardiovascular Disease and Diabetes measure is a combination of two measures (Statin Therapy Received for Patients with Cardiovascular Disease and Statin Therapy Received for Patients with Diabetes). The denominators and numerators for his combined measure will be calculated to produce one rate for this measure. The minimum denominator requirement for this measure is 10 eligible Members.
[4] Reporting Only Measure. Not eligible for incentive dollars.
[5] Reporting Only Measure. Measure will be scoreable for MY2026.
† Tier 1: If baseline is at or above 50th percentile: Goal is the 50th percentile, Tier 2: If baseline is at or above 50th percentile: Goal is the 50th percentile plus 1%.

2025 50TH PERCENTILE RATES		
Domain	**Measure Name**	**50th Percentile Rate**
Clinical Quality	Asthma Medication Ratio	68%
Clinical Quality	Colorectal Cancer Screening	40%
Clinical Quality	Controlling High Blood Pressure	66%
Clinical Quality	Diabetes Care - Blood Pressure Control <140/90	71%
Clinical Quality	Glycemic Status Assessment for Patients with Diabetes (GSD)	59%
Clinical Quality	Diabetes Care - Kidney Health Evaluation	38%
Clinical Quality	Developmental Screening	38%
Clinical Quality	Adult Influenza Vaccine	18%
Clinical Quality	Adult Pneumococcal Vaccine	46%
Clinical Quality	Adult Td/Tdap Vaccine	40%
Clinical Quality	Adult Zoster Vaccine	13%
Clinical Quality	Post Discharge Follow Up	61%
Clinical Quality	Statin Therapy Received for Patients with Cardiovascular Disease and Diabetes	75%
Clinical Quality	Breast Cancer Screening	55%
Clinical Quality	Cervical Cancer Screening	59%
Clinical Quality	Chlamydia Screening	58%
Clinical Quality	Timeliness of Prenatal Care	87%
Clinical Quality	Postpartum Care	82%
Clinical Quality	Child and Adolescent Well-Care Visits	54%
Clinical Quality	Childhood Immunizations - Combo 10	29%
Clinical Quality	Immunizations for Adolescents - Combo 2	36%
Clinical Quality	Lead Screening for Children	66%
Clinical Quality	Well-Child Visits First 15 Months of Life	62%
Clinical Quality	Well-Child Visits First 30 Months of Life	71%
Clinical Quality	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents -BMI	85%
Clinical Quality	Initial Health Appointment	65%

The 50th percentile goals are based on a combination of national and network performance rates with a trend adjustment factor applied.

APPENDIX 2: *Core Measures Overview*

☑ Population: Adult

Summary of Changes to the 2025 Global Quality P4P Program Guide:

- Update to the asthma reliever medications

MCAS Measure

Asthma Medication Ratio (AMR)

Methodology: HEDIS®

Measure Description: The percentage of Members who are 5-64 years of age and identified as having persistent asthma, who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year (2025).

- Eligible population in this measure meets all of the following criteria:
  1. Members who are 5-64 years of age as of December 31 of the measurement year (2025).
  2. Continuous enrollment with IEHP during the measurement year (2025) and the year prior to the measurement year (2024) with no more than one month gap in continuous enrollment with IEHP during the measurement year (2025) and no more than one month gap in continuous enrollment in the year prior to the measurement year (2024).
  3. Members who had two events of persistent asthma, with at least one event occurring in the measurement year (2025) **and** at least one event occurring in the year prior to the measurement year (2024).

     Examples of persistent asthma events:
     - At least one (1) emergency department visit or acute hospital inpatient encounter with a principal diagnosis of asthma.
     - At least one (1) acute hospital inpatient discharge with a principal diagnosis of asthma on the claim.
     - At least four (4) outpatient visits, that occurred on different dates of services, with any diagnosis of asthma and had at least two (2) asthma medications dispensed (any controller or reliever medication).
     - At least four (4) asthma medications dispensed (any controller or reliever medications).

Denominator: Members 5-64 years of age who meet all criteria for the eligible population.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who had a medication ratio of 0.50 or greater during the measurement year (2025).

ASTHMA CONTROLLER MEDICATIONS:	
Description	**Prescription**
Antibody inhibitors	Omalizumab
Anti-interleukin-4	Dupilumab
Anti-interleukin-5	Benralizumab
Anti-interleukin-5	Mepolizumab
Anti-interleukin-5	Reslizumab
Inhaled steroid combinations	Budesonide-formoterol
Inhaled steroid combinations	Fluticasone-salmeterol
Inhaled steroid combinations	Fluticasone-vilanterol
Inhaled steroid combinations	Formoterol-mometasone
Inhaled corticosteroids	Beclomethasone
Inhaled corticosteroids	Budesonide
Inhaled corticosteroids	Ciclesonide
Inhaled corticosteroids	Flunisolide
Inhaled corticosteroids	Fluticasone
Inhaled corticosteroids	Mometasone
Leukotriene modifiers	Montelukast
Leukotriene modifiers	Zafirlukast
Leukotriene modifiers	Zileuton
Methylxanthines	Theophylline

ASTHMA RELIEVER MEDICATIONS:	
Description	**Prescription**
Short-acting, inhaled beta-2 agonists	Albuterol
Short-acting, inhaled beta-2 agonists	Levalbuterol
Beta2 adrenergic agonist—corticosteroid combination	Albuterol-budesonide

Colorectal Cancer Screening (COL-E)

Summary of Changes to the 2025 Global Quality P4P Program Guide:

- Update to measure title

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 (2025).
  2. Continuous enrollment with IEHP during the measurement year (2025) and the year prior (2024) 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, 2025

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 (2025).
- Flexible sigmoidoscopy during the measurement year (2025) or four years prior to the measurement year (2021).
- Colonoscopy during the measurement year (2025) or the nine years prior to the measurement year (2016).
- CT colonography during the measurement year (2025) or the four years prior to the measurement year (2021).
- Stool DNA with FIT test during the measurement year (2025) or two years prior to the measurement year (2023).

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:

Service	Code Type	Code	Code Description
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
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

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
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) (eg, 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
Colorectal Cancer Screening	CPT	45337	Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, 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

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
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
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

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
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, one to three 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 (2025).

- 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 (2025).
  2. Continuous enrollment during the measurement year (2025) with no more than one gap in continuous enrollment of up to 45 days during the measurement year (2025).
  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 (2024) and June 30 of the measurement year (2025). 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, 2025

Numerator: Members in the denominator who had a BP reading taken during the measurement year (2025), in any of the following settings: office visits, e-visits, telephone visits or online assessments. The most recent BP of the measurement year (2025) will be used to determine compliance for this measure. **Provider must bill one diastolic code, one systolic code and one visit type 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	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)
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	3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM)
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)

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	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.
Office Visit	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.
Office Visit	CPT	99341	Home or residence 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.
Office Visit	CPT	99342	Home or residence 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.
Office Visit	CPT	99344	Home or residence 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, 60 minutes must be met or exceeded.
Office Visit	CPT	99345	Home or residence 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, 75 minutes must be met or exceeded.
Office Visit	CPT	99347	Home or residence 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, 20 minutes must be met or exceeded.
Office Visit	CPT	99348	Home or residence 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, 30 minutes must be met or exceeded.
Office Visit	CPT	99349	Home or residence 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, 40 minutes must be met or exceeded.
Office Visit	CPT	99350	Home or residence 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, 60 minutes must be met or exceeded.
Office 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 OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office 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; 40-64 years.
Office 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; 65 years and older.
Office 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.
Office 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; 40-64 years.
Office 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; 65 years and older.
Office Visit	CPT	99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.
Office Visit	CPT	99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes.
Office Visit	CPT	99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes.
Office Visit	CPT	99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes.
Office Visit	CPT	99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes.
Office Visit	CPT	99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes.
Office Visit	CPT	99429	Unlisted preventive medicine service.
Office Visit	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.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	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.
Office Visit	CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (eg, home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.
Office Visit	HCPCS	G0071	Payment for communication technology-based services for five minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or five minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only.
Office Visit	HCPCS	G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.
Office Visit	HCPCS	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.
Office Visit	HCPCS	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit.
Office Visit	HCPCS	G0463	Hospital outpatient clinic visit for assessment and management of a patient.
Office Visit	HCPCS	T1015	Clinic Visit/encounter, All-inclusive

CODES TO IDENTIFY E-VISITS			
Service	**Code Type**	**Code**	**Code Description**
E-Visit	CPT	98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 5-10 minutes.
E-Visit	CPT	98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 11-20 minutes.
E-Visit	CPT	98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes.
E-Visit	CPT	99421	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 5-10 minutes.
E-Visit	CPT	99422	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 11-20 minutes.
E-Visit	CPT	99423	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes.
E-Visit	HCPCS	G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

CODES TO IDENTIFY TELEPHONE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Telephone Visit	CPT	98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
Telephone Visit	CPT	98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
Telephone Visit	CPT	98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

CODES TO IDENTIFY ONLINE ASSESSMENTS:			
Service	**Code Type**	**Code**	**Code Description**
Online Assessment	CPT	98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
Online Assessment	CPT	98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)
Online Assessment	CPT	99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
Online Assessment	CPT	99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)
Online Assessment	HCPCS	G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment
Online Assessment	HCPCS	G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion
Online Assessment	HCPCS	G2252	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related EM service provided within the previous 7 days nor leading to an EM service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

Diabetes Care - Blood Pressure Control <140/90 (BPD)

Methodology: HEDIS®

Measure Description: The percentage of Members who are 18-75 years of age and have a diagnosis of diabetes (type 1 and type 2), whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year (2025).

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 18-75 years as of December 31 of the measurement year (2025).
    2. Continuous enrollment with IEHP during the measurement year (2025) with no more than one gap in enrollment of up to 45 days.
    3. Members who meet any of the following criteria during the measurement year (2025) or the year prior to the measurement year (2024). Count services that occur over both years:
        - At least two outpatient visits, observation visits, telephone visits, e-visits or virtual check-ins, Emergency Department (ED), nonacute inpatient encounter or nonacute inpatient discharges on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two visits.
        - At least one acute inpatient encounter with a diagnosis of diabetes without telehealth.
        - Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year (2025) or the year prior to the measurement year (2024).
        - At least one acute inpatient with a diagnosis of diabetes on the discharge claim. To identify an acute inpatient discharge:
            - Identify all acute and nonacute inpatient stays
            - Exclude nonacute inpatient stays
            - Identify the discharge date for the stay
- 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 (2025).
    4. Members 66 years of age and older as of December 31 of measurement year (2025) with both frailty and advanced illness.

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

- Anchor Date: December 31, 2025

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.**

CODES TO IDENTIFY DIABETES CARE - BLOOD PRESSURE CONTROL:			
Service	**Code Type**	**Code**	**Code Description**
Systolic Blood Pressure	CPT-CAT-II	3074F	Most recent systolic blood pressure less than 130 mm Hg (DM), (HTN, CKD, CAD)
Systolic Blood Pressure	CPT-CAT-II	3075F	Most recent systolic blood pressure 130-139 mm Hg (DM),(HTN, CKD, CAD)
Systolic Blood Pressure	CPT-CAT-II	3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM)
Diastolic Blood Pressure	CPT-CAT-II	3078F	Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM)
Diastolic Blood Pressure	CPT-CAT-II	3079F	Most recent diastolic blood pressure 80-89 mm Hg (HTN, CKD, CAD) (DM)
Diastolic Blood Pressure	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 (2025) 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 an Glycemic Status Assessment was not done during the measurement year (2025).
- 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 (2025).
    2. Continuous enrollment with IEHP in the measurement year (2025) with no more than one gap of up to 45 days during the measurement year (2025).
    3. Members who meet any of the following criteria during the measurement year (2025) or the year prior to the measurement year (2024). 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 (2025) or the year prior to the measurement year (2024).
        - Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year (2025) or the year prior to the measurement year (2024) and have at least one diagnosis of diabetes during the measurement year (2025) or the year prior to the measurement year (2024).

CODES TO IDENTIFY GLYCEMIC STATUS TESTS:			
Service	**Code Type**	**Code**	**Code Description**
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%
Glycemic Status Result	CPT-CAT-II	3044F	Most Recent Hemoglobin A1c (hba1c) Level Less Than 7.0% (dm)

- Members who met 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 (2025).
    4. Members 66 years of age and older as of December 31 of measurement year (2025) 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, 2025

Numerator: Members in the denominator who had the most recent glycemic status test result of <8 during the measurement year (2025).

Diabetes Care - Kidney Health Evaluation (KED)

Summary of Changes to the 2025 Global Quality P4P Program Guide:

- Update to the eligible population
- Update to the exclusions

Methodology: HEDIS®

Measure Description: The percentage of Members who are 18-85 years of age and have a diagnosis of diabetes (type 1 and type 2), who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year (2025).

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 18-85 years of age as of December 31 of the measurement year (2025).
    2. Continuous enrollment with IEHP during the measurement year (2025) with no more than one gap in continuous enrollment with IEHP of up to 45 days during the measurement year (2025).
    3. Members who meet any of the following criteria during the measurement year (2025) or the year prior to the measurement year (2024). 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 (2025) or the year prior to the measurement year (2024).
        - Members who were dispensed insulin or hypoglycemics/antihyperglycemics basis during the measurement year (2025) or the year prior to the measurement year (2024) and have at least one diagnosis of diabetes during the measurement year (2025) or the year prior to the measurement year (2024).
- Members who meet any of the following criteria are excluded:
    1. Members in hospice.
    2. Members with evidence of End-stage Renal Disease (ESRD) any time in the Members history on or before December 31 of the measurement year (2025).
    3. Members receiving palliative care.
    4. Members who expired at any time during the measurement year (2025).
    5. Members who had dialysis any time during the member's history on or prior to December 31 of the measurement year (2025).
    6. Members 66-80 years of age and older as of December 31 of measurement year (2025) with both frailty and advanced illness.
    7. Members 81 years of age and older as of December 31 with at least two indications of frailty on different dates of service during the measurement year (2025).

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

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who received both an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) during the measurement year (2025), on the same or different dates of service. **The following is required for compliance in this measure:**

- At least one estimated glomerular filtration rate (eGFR).
- At least one urine albumin-creatinine ratio (uACR):
  - Quantitative urine albumin lab test **AND** urine creatinine lab test that are 4 days or less apart.
    OR
  - Urine albumin-creatinine ratio lab test.

CODES TO IDENTIFY ESTIMATED GLOMERULAR FILTRATION RATE:			
Service	**Code Type**	**Code**	**Code Description**
Estimated Glomerular Filtration Rate	CPT	80047	Basic metabolic panel (Calcium, ionized) This panel must include the following: Calcium, ionized (82330) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea Nitrogen (BUN) (84520)
Estimated Glomerular Filtration Rate	CPT	80048	Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)
Estimated Glomerular Filtration Rate	CPT	80050	General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)
Estimated Glomerular Filtration Rate	CPT	80053	Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520)
Estimated Glomerular Filtration Rate	CPT	80069	Renal function panel this panel must include the following: Albumin (82040) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphorus inorganic (phosphate) (84100) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)

CODES TO IDENTIFY ESTIMATED GLOMERULAR FILTRATION RATE:			
Service	**Code Type**	**Code**	**Code Description**
Estimated Glomerular Filtration Rate	CPT	82565	Creatinine; Blood
Estimated Glomerular Filtration Rate	LOINC	50044-7	Glomerular Filtration Rate/1.73 Sq M.predicted Among Females [volume Rate/area] In Serum, Plasma Or Blood By Creatinine-based Formula (mdrd)
Estimated Glomerular Filtration Rate	LOINC	50210-4	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood By Cystatin C-based Formula
Estimated Glomerular Filtration Rate	LOINC	50384-7	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood By Creatinine-based Formula (schwartz)
Estimated Glomerular Filtration Rate	LOINC	62238-1	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood By Creatinine-based Formula (ckd-epi)
Estimated Glomerular Filtration Rate	LOINC	69405-9	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood
Estimated Glomerular Filtration Rate	LOINC	70969-1	Glomerular Filtration Rate/1.73 Sq M.predicted Among Males [volume Rate/area] In Serum, Plasma Or Blood By Creatinine-based Formula (mdrd)
Estimated Glomerular Filtration Rate	LOINC	77147-7	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood By Creatinine-based Formula (mdrd)
Estimated Glomerular Filtration Rate	LOINC	94677-2	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood By Creatinine And Cystatin C-based Formula (ckd-epi)
Estimated Glomerular Filtration Rate	LOINC	98979-8	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood By Creatinine-based Formula (ckd-epi 2021)
Estimated Glomerular Filtration Rate	LOINC	98980-6	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood By Creatinine And Cystatin C-based Formula (ckd-epi 2021)
Estimated Glomerular Filtration Rate	LOINC	102097-3	Glomerular Filtration Rate/1.73 sq M.predicted [volume Rate/area] In Serum, Plasma or Blood by Creatinine, Cystatin C And Urea-based formula (CKiD)

CODES TO IDENTIFY QUANTITATIVE URINE ALBUMIN LAB TEST:			
Service	**Code Type**	**Code**	**Code Description**
Quantitative Urine Albumin	CPT	82043	Albumin; Urine (e.g, Microalbumin), Quantitative
Quantitative Urine Albumin	LOINC	100158-5	Microalbumin [mass/volume] In Urine Collected For Unspecified Duration
Quantitative Urine Albumin	LOINC	14957-5	Microalbumin [mass/volume] In Urine
Quantitative Urine Albumin	LOINC	1754-1	Albumin [mass/volume] In Urine
Quantitative Urine Albumin	LOINC	21059-1	Albumin [mass/volume] In 24 Hour Urine
Quantitative Urine Albumin	LOINC	30003-8	Microalbumin [mass/volume] In 24 Hour Urine
Quantitative Urine Albumin	LOINC	43605-5	Microalbumin [mass/volume] In 4 Hour Urine
Quantitative Urine Albumin	LOINC	53530-2	Microalbumin [mass/volume] In 24 Hour Urine By Detection Limit <= 1.0 Mg/l
Quantitative Urine Albumin	LOINC	53531-0	Microalbumin [mass/volume] In Urine By Detection Limit <= 1.0 Mg/l
Quantitative Urine Albumin	LOINC	57369-1	Microalbumin [mass/volume] In 12 Hour Urine
Quantitative Urine Albumin	LOINC	89999-7	Microalbumin [mass/volume] In Urine By Detection Limit <= 3.0 Mg/l

CODES TO IDENTIFY URINE CREATININE LAB TEST:			
Service	**Code Type**	**Code**	**Code Description**
Urine Creatinine	CPT	82570	Creatinine; Other Source
Urine Creatinine	LOINC	20624-3	Creatinine [mass/volume] In 24 Hour Urine
Urine Creatinine	LOINC	2161-8	Creatinine [mass/volume] In Urine
Urine Creatinine	LOINC	35674-1	Creatinine [mass/volume] In Urine Collected For Unspecified Duration
Urine Creatinine	LOINC	39982-4	Creatinine [mass/volume] In Urine - baseline
Urine Creatinine	LOINC	57344-4	Creatinine [mass/volume] In 2 Hour Urine
Urine Creatinine	LOINC	57346-9	Creatinine [mass/volume] In 12 Hour Urine
Urine Creatinine	LOINC	58951-5	Creatinine [mass/volume] In Urine --2nd Specimen

CODES TO IDENTIFY URINE ALBUMIN-CREATININE RATIO LAB TEST:			
Service	**Code Type**	**Code**	**Code Description**
Urine Albumin-Creatinine Ratio	LOINC	13705-9	Albumin/creatinine [mass Ratio] In 24 Hour Urine
Urine Albumin-Creatinine Ratio	LOINC	14958-3	Microalbumin/creatinine [mass Ratio] In 24 Hour Urine
Urine Albumin-Creatinine Ratio	LOINC	14959-1	Microalbumin/creatinine [mass Ratio] In Urine
Urine Albumin-Creatinine Ratio	LOINC	30000-4	Microalbumin/creatinine [ratio] In Urine
Urine Albumin-Creatinine Ratio	LOINC	44292-1	Microalbumin/creatinine [mass Ratio] In 12 Hour Urine
Urine Albumin-Creatinine Ratio	LOINC	59159-4	Microalbumin/creatinine [ratio] In 24 Hour Urine
Urine Albumin-Creatinine Ratio	LOINC	76401-9	Albumin/creatinine [ratio] In 24 Hour Urine
Urine Albumin-Creatinine Ratio	LOINC	77253-3	Microalbumin/creatinine [ratio] In Urine By Detection Limit <= 1.0 Mg/l
Urine Albumin-Creatinine Ratio	LOINC	77254-1	Microalbumin/creatinine [ratio] In 24 Hour Urine By Detection Limit <= 1.0 Mg/l
Urine Albumin-Creatinine Ratio	LOINC	89998-9	Microalbumin/creatinine [ratio] In Urine By Detection Limit <= 3.0 Mg/l
Urine Albumin-Creatinine Ratio	LOINC	9318-7	Albumin/creatinine [mass Ratio] In Urine

Adult Influenza Vaccine (AIV)

Methodology: IEHP – HEDIS Modified Measure

Measure Description: The percentage of Members 19 years of age and older who received an influenza vaccine on or between July 1 of the year prior to the measurement year (2024) and June 30 of the measurement year (2025).

- The eligible population in this measure meets all of the following criteria:
  - Continuous enrollment with IEHP in the measurement year (2025) with no more than one gap of up to 45 days during the measurement year.

Denominator: Members 19 years of age or older who meet all criteria for the eligible population.

- Anchor Date: June 30, 2025

Numerator: Members in the denominator who received an influenza vaccine on or between July 1, 2024-June 30, 2025.

CODES TO IDENTIFY ADULT INFLUENZA VACCINE:			
Antigen	**Code Type**	**Code**	**Code Description**
Adult Influenza Vaccine	CPT	90630	Influenza Virus Vaccine, Quadrivalent (Iiv4), Split Virus, Preservative Free, For Intradermal Use
Adult Influenza Vaccine	CPT	90653	Influenza Vaccine, Inactivated (Iiv), Subunit, Adjuvanted, For Intramuscular Use
Adult Influenza Vaccine	CPT	90654	Influenza Virus Vaccine, Trivalent (Iiv3), Split Virus, Preservative Free, For Intradermal Use
Adult Influenza Vaccine	CPT	90656	Influenza Virus Vaccine, Trivalent (Iiv3), Split Virus, Preservative Free, 0.5 Ml Dosage, For Intramuscular Use
Adult Influenza Vaccine	CPT	90658	Influenza Virus Vaccine, Trivalent (Iiv3), Split Virus, 0.5 Ml Dosage, For Intramuscular Use
Adult Influenza Vaccine	CPT	90660	Influenza Virus Vaccine, Trivalent, Live (Laiv3), For Intranasal Use
Adult Influenza Vaccine	CPT	90661	Influenza Virus Vaccine, Trivalent (Cciiv3), Derived From Cell Cultures, Subunit, Preservative And Antibiotic Free, 0.5 Ml Dosage, For Intramuscular Use
Adult Influenza Vaccine	CPT	90662	Influenza Virus Vaccine (Iiv), Split Virus, Preservative Free, Enhanced Immunogenicity Via Increased Antigen Content, For Intramuscular Use
Adult Influenza Vaccine	CPT	90672	Influenza Virus Vaccine, Quadrivalent, Live (Laiv4), For Intranasal Use
Adult Influenza Vaccine	CPT	90673	Influenza Virus Vaccine, Trivalent (Riv3), Derived From Recombinant Dna, Hemagglutinin (Ha) Protein Only, Preservative And Antibiotic Free, For Intramuscular Use

CODES TO IDENTIFY ADULT INFLUENZA VACCINE:			
Antigen	**Code Type**	**Code**	**Code Description**
Adult Influenza Vaccine	CPT	90674	Influenza Virus Vaccine, Quadrivalent (Cciiv4), Derived From Cell Cultures, Subunit, Preservative And Antibiotic Free, 0.5 Ml Dosage, For Intramuscular Use
Adult Influenza Vaccine	CPT	90682	Influenza Virus Vaccine, Quadrivalent (RIV4), Derived From Recombinant DNA, Hemagglutinin (HA) Protein Only, Preservative And Antibiotic Free, For Intramuscular Use
Adult Influenza Vaccine	CPT	90686	Influenza Virus Vaccine, Quadrivalent (Iiv4), Split Virus, Preservative Free, 0.5 Ml Dosage, For Intramuscular Use
Adult Influenza Vaccine	CPT	90688	Influenza Virus Vaccine, Quadrivalent (Iiv4), Split Virus, 0.5 Ml Dosage, For Intramuscular Use
Adult Influenza Vaccine	CPT	90689	Influenza Virus Vaccine Quadrivalent (Iiv4), Inactivated, Adjuvanted, Preservative Free, 0.25 Ml Dosage, For Intramuscular Use
Adult Influenza Vaccine	CPT	90694	Influenza Virus Vaccine, Quadrivalent (aIIV4), Inactivated, Adjuvanted, Preservative Free, 0.5 mL Dosage, For Intramuscular Use
Adult Influenza Vaccine	CPT	90756	Influenza Virus Vaccine, Quadrivalent (Cciiv4), Derived From Cell Cultures, Subunit, Antibiotic Free, 0.5ml Dosage, For Intramuscular Use

Adult Zoster Vaccine (AISZ)

Summary of Changes to the 2025 Global Quality P4P Program Guide:

- Update to the numerator criteria #1

Methodology: IEHP – HEDIS Modified Measure

Measure Description: The percentage of Members 50 years of age and older, who received the appropriate herpes zoster vaccine in the measurement year (2025).

- The eligible population in this measure meets all of the following criteria:
  - Continuous enrollment with IEHP in the measurement year (2025) with no more than one gap of up to 45 days during the measurement year (2025).

Denominator: Members 50 years of age and older in the eligible population.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who were administered the herpes zoster vaccine by meeting one of the criteria below:

1) Members who received two doses of the herpes zoster recombinant vaccine (at least 28 days apart), on October 1, 2017, through the end of the measurement year (2025).

   OR

2) Members who had anaphylaxis from the herpes zoster vaccine any time before or during the measurement year (2025).

CODE TO IDENTIFY ADULT ZOSTER VACCINE:			
Antigen	**Code Type**	**Code**	**Code Description**
Adult Zoster Vaccine	CPT	90750	Zoster (shingles) vaccine (HZV), recombinant, subunit, adjuvanted, for intramuscular use

Adult Pneumococcal Vaccine (AISP)

Summary of Changes to the 2025 Global Quality P4P Program Guide:

- Update to age range in measure description and denominator

Methodology: IEHP – HEDIS Modified Measure

Measure Description: The percentage of Members 65 years of age and older, who received the pneumococcal vaccine by the end of the measurement year (2025).

- The eligible population in this measure meets all of the following criteria:
  - o Continuous enrollment with IEHP in the measurement year (2025) with no more than one gap of up to 45 days during the measurement year (2025).

Denominator: Members 65 years of age, or older, in the eligible population.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who were administered the pneumococcal vaccine by meeting one of the criteria below:

1) Members in the denominator who received at least one dose of an adult pneumococcal vaccine on or after the Member's 19th birthday and before or during the measurement year (2025).

   OR

2) Members who had anaphylaxis from the pneumococcal vaccine any time before or during the measurement year (2025).

CODES TO IDENTIFY ADULT PNEUMOCOCCAL VACCINE:			
Antigen	**Code Type**	**Code**	**Code Description**
Adult Pneumococcal Vaccine	CPT	90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use; Includes Prevnar 13
Adult Pneumococcal Vaccine	CPT	90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use;Includes Vaxneuvance
Adult Pneumococcal Vaccine	CPT	90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use
Adult Pneumococcal Vaccine	CPT	90732	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use; Includes Pneumovax 23
Adult Pneumococcal Vaccine	HCPCS	G0009	Administration of pneumococcal vaccine

Adult Td/Tdap Vaccine (AIST)

Methodology: IEHP – HEDIS Modified Measure

Measure Description: The percentage of Members 19 years of age and older, who received the tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap) vaccine in the measurement year (2025).

- The eligible population in this measure meets all of the following criteria:
  - o Continuous enrollment with IEHP in the measurement year (2025) with no more than one gap of up to 45 days during the measurement year (2025).

Denominator: Members 19years of age and older in the eligible population.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who were administered the Td/Tdap vaccine by meeting one of the criteria below:

1) Members in the denominator who received at least one Td vaccine or one Tdap vaccine between 9 years prior to the measurement year (2016) and the end of the measurement year (2025).

   OR

2) Members with a history of at least one of the of the following any time before or during the measurement year (2025):
   - Members who had anaphylaxis from the diphtheria, tetanus, or pertussis vaccine.
   - Members who had encephalitis due to the diphtheria, tetanus, or pertussis vaccine.

CODES TO IDENTIFY ADULT TD/TDAP VACCINE:			
Antigen	**Code Type**	**Code**	**Code Description**
Adult Td Vaccine	CPT	90714	Tetanus and diphtheria toxoids adsorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use;Includes TDVAX; Includes Tenivac
Adult Td Vaccine	CPT	90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use;Includes Adacel; Includes Boostrix

Adult Hepatitis B Vaccine (AISH)

Methodology: IEHP – HEDIS Modified Measure

Measure Description: The percentage of Members 19-59 years old, who received the appropriate Hepatitis B vaccine in the measurement year (2025).

- The eligible population in this measure meets all the following criteria:
  - Continuous enrollment with IEHP during the measurement year (2025) with no more than one gap in enrollment of up to 45 days.
- Members who meet any of the following criteria are excluded:
  - Members in hospice.
  - Members who expire at any time during the measurement year (2025).

Denominator: Members who are 19-59 years old, during the measurement year (2025).

- Anchor Date: December 31st of the measurement year (2025).

Numerator: Members in the denominator who were administered the Hepatitis B vaccine. Any of the following meet criteria:

- Members who received at least 3 doses of the childhood Hepatitis B vaccine (on different dates of service) on or before their 19th birthday.
- Members who received a Hepatitis B vaccine series on or after their 19th birthday, before or during the measurement year (2025), including any of the following:
  - At least 2 doses (administered at least 28 days apart) of the recommended two-dose adult Hepatitis B vaccine; or
  - At least 3 doses (administered on different days of service) of any other recommended adult Hepatitis B vaccine.
- Members who had a Hepatitis B surface antigen, Hepatitis B surface antibody or total antibody to Hepatitis B core antigen test, with a positive result anytime before or during the measurement year (2025). Any of the following meet criteria:
  - A test result of > 10 mIU/mL; or
  - A test result of immunity
- Members with a history of Hepatitis B illness any time before or during the measurement year (2025).
- Members who had anaphylaxis from the Hepatitis B vaccine any time before or during the measurement year (2025).

CODES TO IDENTIFY ADULT HEPATITIS B VACCINE:			
Antigen	**Code Type**	**Code**	**Code Description**
Adult Hepatitis B Vaccine	CPT	90739	Hepatitis B vaccine (HepB), CpG-adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use
Adult Hepatitis B Vaccine	CPT	90759	Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use
Adult Hepatitis B Vaccine	CPT	90743	Hepatitis B vaccine (HepB), adolescent, 2 dose schedule, for intramuscular use; Includes: Recombivax HB
Adult Hepatitis B Vaccine	CPT	90744	Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use
Adult Hepatitis B Vaccine	CPT	90746	Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use; Includes: Energix-B, Recombivax HB
Adult Hepatitis B Vaccine	CPT	90747	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use;Includes: Energix-B
Adult Hepatitis B Vaccine	CPT	90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use; Includes: Pediarix
Adult Hepatitis B Vaccine	CPT	90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use; Includes: Vaxelis
Adult Hepatitis B Vaccine	CPT	90748	Hepatitis B and Haemophilus influenzae type b vaccine (Hib-HepB), for intramuscular use; Includes: Comvax
Adult Hepatitis B Vaccine	CPT	90740	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use; Includes: Recombivax HB
Adult Hepatitis B Vaccine	HCPCS	G0010	Administration of hepatitis b vaccine (G0010)

CODES TO IDENTIFY HISTORY OF HEPATITIS B:			
Service	**Code Type**	**Code**	**Code Description**
History of Hepatitis B	ICD10CM	B16.0	Acute hepatitis B with delta-agent with hepatic coma
History of Hepatitis B	ICD10CM	B16.1	Acute hepatitis B with delta-agent without hepatic coma
History of Hepatitis B	ICD10CM	B16.2	Acute hepatitis B without delta-agent with hepatic coma
History of Hepatitis B	ICD10CM	B16.9	Acute hepatitis B without delta-agent and without hepatic coma
History of Hepatitis B	ICD10CM	B17.0	Acute delta-(super) infection of hepatitis B carrier
History of Hepatitis B	ICD10CM	B18.0	Chronic viral hepatitis B with delta-agent
History of Hepatitis B	ICD10CM	B18.1	Chronic viral hepatitis B without delta-agent
History of Hepatitis B	ICD10CM	B19.10	Unspecified viral hepatitis B without hepatic coma
History of Hepatitis B	ICD10CM	B19.11	Unspecified viral hepatitis B with hepatic coma

Post Discharge Follow-Up (PDFU)

Methodology: IEHP-Defined Measure

Measure Description: The percentage of Members, 18 years and older who have follow-up visits with a Provider within required timeframes. For this measure, two rates are calculated and the average of both rates are used as the final score.

Rate 1: Follow-Up Visit High-Risk Members – this measure assesses the percentage of Members identified as "high-risk" who were discharged from an acute or nonacute inpatient stay during the measurement year (2025) who also had a follow up visit with a provider within seven days of discharge.

- Anchor Date: Assigned Provider at the end of the 7 day follow-up window.

Rate 2: Follow-Up Visit with non-High-Risk Members - this measure assesses the percentage of members identified as "rising and low risk" who were discharged from an acute or nonacute inpatient stay during the measurement year (2025) who also had a follow-up visit with a provider within 30 days of discharge.

- Anchor Date: Assigned Provider at the end of the 30 day follow-up window.

As part of IEHPs 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 the three categories: High, Rising and Low Risk. IEHP employs the Chronic Illness and Disability Payment System (CDPS) and Medicaid Rx (MRx) model (CDPS+MRx), a combined diagnostic and pharmacy model, to identify high-, rising- and low-risk members. The system was developed by the University of California, San Diego, and has been adopted by the Department of Health Care Services (DHCS) of the State of California for use in its rate setting methodology with Medi-Cal Managed Care Plans (MCPs).

CDPS+MRx uses clinical and pharmaceutical data from the prior 12 months to generate predictive risk scores for the next 12 months.

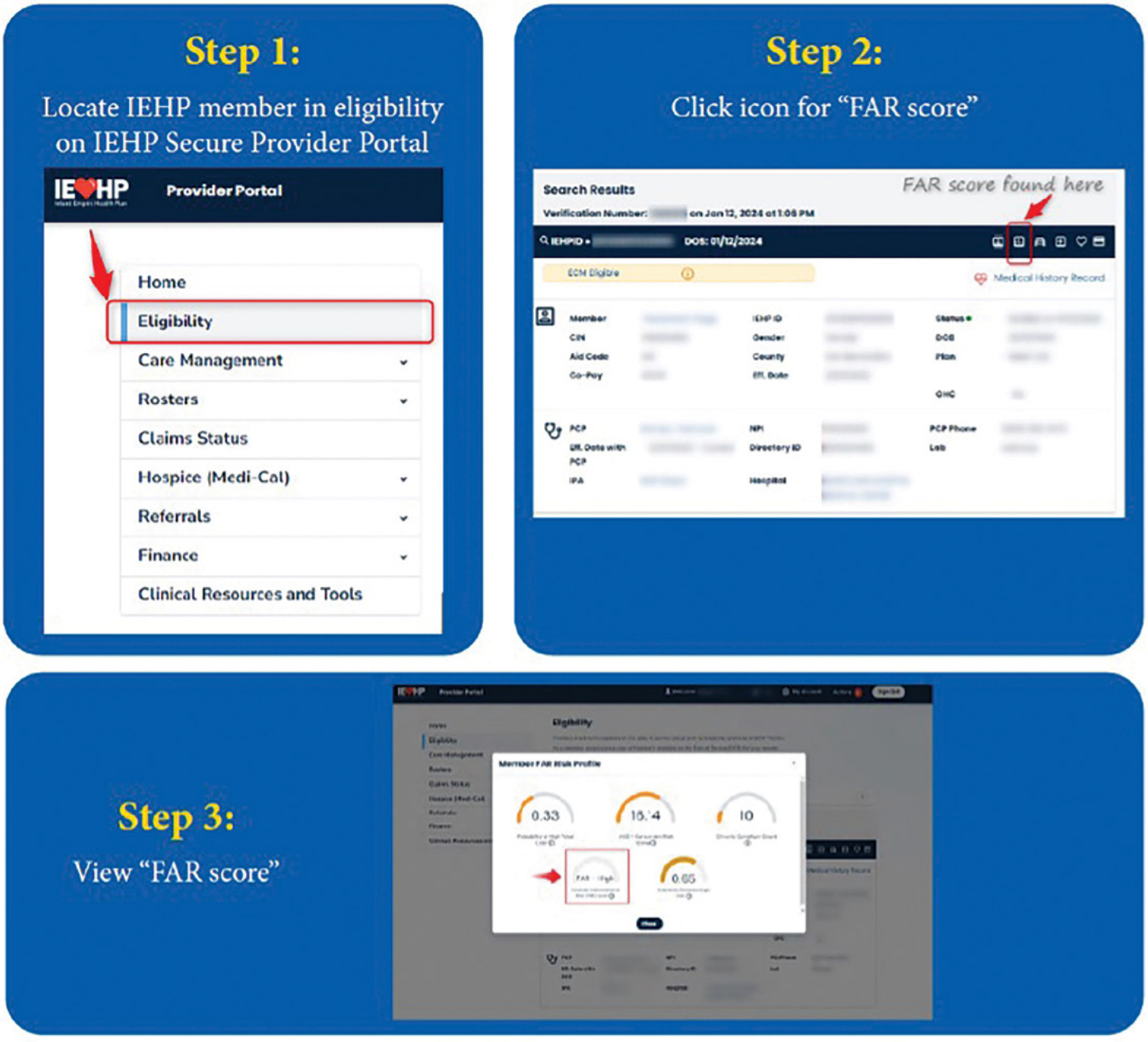
The CDPS+MRx system measures the morbidity burden of patient populations based on age, gender, and diagnostic markers.

For member stratification, IEHP uses the CDPS+MRx risk scores, along with other inputs including Social Determinants of Health (SDOH) indices, and other clinical indicators to further stratify members into high, rising, and low risk tiers.

- The eligible population in this measure meets all of the following criteria:
    1. Members who are 18 years of age, or older, by December 31, 2025

2. To be eligible for this measure, IEHP Members must be enrolled with IEHP on the date of the discharge through 30 days after the discharge (31 total days).
3. Discharged to home from an acute or nonacute inpatient hospital stay during the measurement year (2025)

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



CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.
Office Visit	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.

CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	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.
Office Visit	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.
Office 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.
Office 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; 40-64 years.
Office 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; 65 years and older.
Office 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.
Office 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; 40-64 years.
Office 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; 65 years and older.
Office Visit	CPT	99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.
Office Visit	CPT	99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes.
Office Visit	CPT	99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes.
Office Visit	CPT	99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes.
Office Visit	CPT	99411	Preventive Medicine Counseling And/or Risk Factor Reduction Intervention(s) Provided To Individuals In A Group Setting (separate Procedure); Approximately 30 Minutes

CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99412	Preventive Medicine Counseling And/or Risk Factor Reduction Intervention(s) Provided To Individuals In A Group Setting (separate Procedure); Approximately 60 Minutes
Office Visit	CPT	99429	Unlisted Preventive Medicine Service
Office Visit	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.
Office Visit	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.
Office Visit	CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (eg, home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99495*	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge, At least moderate level of medical decision making during the service period, Face-to-face visit, within 14 calendar days of discharge.
Office Visit	CPT	99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge, High level of medical decision making during the service period, Face-to-face visit, within 7 calendar days of discharge.

CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	HCPCS	G0402	Initial Preventive Physical Examination; Face-to-face Visit, Services Limited To New Beneficiary During The First 12 Months Of Medicare Enrollment (g0402)
Office Visit	HCPCS	G0438	Annual Wellness Visit; Includes A Personalized Prevention Plan Of Service (pps), Initial Visit (g0438)
Office Visit	HCPCS	G0439	Annual Wellness Visit, Includes A Personalized Prevention Plan Of Service (pps), Subsequent Visit (g0439)
Office Visit	HCPCS	G0463	Hospital outpatient clinic visit for assessment and management of a patient.
Office Visit	HCPCS	T1015	Clinic visit/encounter, all-inclusive.

CODES TO IDENTIFY TELEPHONE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Telephone Visit	CPT	98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
Telephone Visit	CPT	98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
Telephone Visit	CPT	98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

CODES TO IDENTIFY ONLINE ASSESSMENTS:			
Service	**Code Type**	**Code**	**Code Description**
Online Assessment	CPT	98970	Qualified Nonphysician Health Care Professional Online Digital Assessment And Management, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 5-10 Minutes
Online Assessment	CPT	98971	Qualified Nonphysician Health Care Professional Online Digital Assessment And Management, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 11-20 Minutes
Online Assessment	CPT	98972	Qualified Nonphysician Health Care Professional Online Digital Assessment And Management, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 21 Or More Minutes
Online Assessment	CPT	98980	Remote Therapeutic Monitoring Treatment Management Services, Physician Or Other Qualified Health Care Professional Time In A Calendar Month Requiring At Least One Interactive Communication With The Patient Or Caregiver During The Calendar Month; First 20 minutes
Online Assessment	CPT	98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)
Online Assessment	CPT	99421	Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 5-10 Minutes
Online Assessment	CPT	99422	Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 11-20 Minutes
Online Assessment	CPT	99423	Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 21 Or More Minutes
Online Assessment	CPT	99457	Remote Physiologic Monitoring Treatment Management Services, Clinical Staff/physician/other Qualified Health Care Professional Time In A Calendar Month Requiring Interactive Communication With The Patient/ caregiver During The Month; First 20 Minutes
Online Assessment	CPT	99458	Remote Physiologic Monitoring Treatment Management Services, Clinical Staff/physician/other Qualified Health Care Professional Time In A Calendar Month Requiring Interactive Communication With The Patient/ caregiver During The Month; Each Additional 20 minutes (List separately in addition to code for primary procedure)
Online Assessment	HCPCS	G0071	Payment for communication technology-based services for 5 minutes or more of a virtual (nonface-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only

CODES TO IDENTIFY ONLINE ASSESSMENTS:			
Service	**Code Type**	**Code**	**Code Description**
Online Assessment	HCPCS	G2010	Remote Evaluation Of Recorded Video And/or Images Submitted By An Established Patient (e.g., Store And Forward), Including Interpretation With Follow-up With The Patient Within 24 Business Hours, Not Originating From A Related E/m Service Provided Within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
Online Assessment	HCPCS	G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment
Online Assessment	HCPCS	G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion
Online Assessment	HCPCS	G2252	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related EM service provided within the previous 7 days nor leading to an EM service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

**Code can only be applied to follow-up visits for non-high-risk Members.*

Note: Visits with an Urgent Care will not be accepted for the Post Discharge Follow-Up measure.

The following are excluded from the measure:

1. Hospice
2. Skilled Nursing Facility
3. Deliveries

Statin Therapy Received for Patients with Cardiovascular Disease (SPC)

Methodology: HEDIS®

Measure Description: The percentage of men who are 21-75 years of age and women who are 40-75 years of age during the measurement year (2025), who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year (2025).

- Eligible population in this measure meets all of the following criteria:
  1. Men who are 21-75 years of age as of December 31 of the measurement year (2025).
  2. Women who are 40-75 years of age as of December 31 of the measurement year (2025).
  3. Continuous enrollment with IEHP during the measurement year (2025) and the year prior (2024) with no more than one gap in continuous enrollment with IEHP of up to 45 days during each year of the continuous enrollment with IEHP period.

Denominator: Men who are 21-75 years of age and women who are 40-75 who meet all criteria for the eligible population.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who had at least one dispensing event for high-intensity or moderate-intensity statin medication during the measurement year (2025).

HIGH AND MODERATE-INTENSITY STATIN MEDICATIONS:	
Description	**Prescription**
High-intensity statin therapy	Atorvastatin 40-80 mg
High-intensity statin therapy	Amlodipine-atorvastatin 40-80 mg
High-intensity statin therapy	Rosuvastatin 20-40 mg
High-intensity statin therapy	Simvastatin 80 mg
High-intensity statin therapy	Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	Atorvastatin 10-20 mg
Moderate-intensity statin therapy	Amlodipine-atorvastatin 10-20 mg
Moderate-intensity statin therapy	Rosuvastatin 5-10 mg
Moderate-intensity statin therapy	Simvastatin 20-40 mg
Moderate-intensity statin therapy	Ezetimibe-simvastatin 20-40 mg
Moderate-intensity statin therapy	Pravastatin 40-80 mg
Moderate-intensity statin therapy	Lovastatin 40 mg
Moderate-intensity statin therapy	Fluvastatin 40-80 mg
Moderate-intensity statin therapy	Pitavastatin 1-4 mg

Statin Therapy Received for Patients with Diabetes (SPD)

Methodology: HEDIS®

Measure Description: The percentage of Members who are 40-75 years of age during the measurement year (2025) with diabetes who did not have clinical atherosclerotic cardiovascular disease (ASCVD) who were dispensed at least one statin medication of any intensity during the measurement year (2025).

- Eligible population in this measure meets all of the following criteria:
    1. Members who 40-75 years as of December 31 of the measurement year (2025).
    2. Continuous enrollment with IEHP during the measurement year (2025) and the year prior (2024) with no more than one gap in continuous enrollment with IEHP of up to 45 days during each year of the continuous enrollment with IEHP period.

Denominator: Members who are 40-75 years of age who meet all criteria for the eligible population.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who had at least one dispensing event for any intensity statin medication during the measurement year (2025).

HIGH, MODERATE AND LOW-INTENSITY STATIN MEDICATIONS:	
Description	**Prescription**
High-intensity statin therapy	Atorvastatin 40-80 mg
High-intensity statin therapy	Amlodipine-atorvastatin 40-80 mg
High-intensity statin therapy	Rosuvastatin 20-40 mg
High-intensity statin therapy	Simvastatin 80 mg
High-intensity statin therapy	Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	Atorvastatin 10-20 mg
Moderate-intensity statin therapy	Amlodipine-atorvastatin 10-20 mg
Moderate-intensity statin therapy	Rosuvastatin 5-10 mg
Moderate-intensity statin therapy	Simvastatin 20-40 mg
Moderate-intensity statin therapy	Ezetimibe-simvastatin 20-40 mg
Moderate-intensity statin therapy	Pravastatin 40-80 mg
Moderate-intensity statin therapy	Lovastatin 40 mg
Moderate-intensity statin therapy	Fluvastatin 40-80 mg
Moderate-intensity statin therapy	Pitavastatin 1-4 mg
Low-intensity statin therapy	Ezetimibe-simvastatin 10 mg
Low-intensity statin therapy	Fluvastatin 20 mg
Low-intensity statin therapy	Lovastatin 10-20 mg
Low-intensity statin therapy	Pravastatin 10-20 mg
Low-intensity statin therapy	Simvastatin 5-10 mg

☑ Population: Adult and Adolescent

Use of Imaging Studies for Low Back Pain (LBP)

Methodology: HEDIS®

Measure Description: The percentage of Members 18 - 75 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

- Index Episode Start Date (IESD). The earliest date of service for an eligible encounter during the Intake Period with a principal diagnosis of low back pain.
- A period of 180 days (six months) prior to the IESD when the member had no claims/encounters with any diagnosis of low back pain.

Exclude Members with any of the following:

- In *hospice* or using hospice services during the measurement period (2025).
- *Cancer*. Cancer any time during the Member's history through 28 days after the IESD.
- *Recent trauma*. Trauma any time during the three months (90 days) prior to the IESD through 28 days after the IESD.
- *Intravenous drug abuse*. IV drug abuse any time during the 12 months (one year) prior to the IESD through 28 days after the IESD.
- *Neurologic impairment*. Neurologic impairment any time during the 12 months (one year) prior to the IESD through 28 days after the IESD.
- *HIV*. HIV any time during the Member's history through 28 days after the IESD.
- *Spinal infection*. Spinal infection any time during the 12 months (one year) prior to the IESD through 28 days after the IESD.
- *Major organ transplant*. Major organ transplant any time in the Member's history through 28 days after the IESD.
- *Prolonged use of corticosteroids*. 90 consecutive days of corticosteroid treatment any time during the 12 months (one year) prior to and including the IESD.
- *Osteoporosis*. Osteoporosis therapy or a dispensed prescription to treat osteoporosis any time during the Member's history through 28 days after the IESD.
- *Fragility fracture*. Fragility fracture any time during the three months (90 days) prior to the IESD through 28 days after the IESD.
- *Lumbar surgery*. Lumbar surgery any time during the Member's history through 28 days after the IESD.
- *Spondylopathy*. Spondylopathy any time during the Member's history through 28 days after the IESD.
- *Palliative care*. Members receiving palliative care during the measurement year (2025).

- Members who expired at any time during the Measurement year (2025).
- Members 66 years of age and older as of December 31 of measurement year (2025) with both frailty and advanced illness.

Denominator: All Members aged 18-75 as of December 31 of the measurement year (2025) with a principal diagnosis of uncomplicated low back pain during the measurement year (2025).

Numerator: Members in the denominator who received an imaging study with a diagnosis of uncomplicated low back pain on the IESD or in the 28 days following the IESD.

CODES TO IDENTIFY UNCOMPLICATED LOW BACK PAIN:			
Service	**Code Type**	**Code**	**Code Description**
Uncomplicated Low Back Pain	ICD10CM	M47.26	Other Spondylosis With Radiculopathy, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M47.27	Other Spondylosis With Radiculopathy, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M47.28	Other Spondylosis With Radiculopathy, Sacral And Sacrococcygeal Region
Uncomplicated Low Back Pain	ICD10CM	M47.816	Spondylosis Without Myelopathy Or Radiculopathy, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M47.817	Spondylosis Without Myelopathy Or Radiculopathy, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M47.818	Spondylosis Without Myelopathy Or Radiculopathy, Sacral And Sacrococcygeal Region
Uncomplicated Low Back Pain	ICD10CM	M47.896	Other Spondylosis, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M47.897	Other Spondylosis, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M47.898	Other Spondylosis, Sacral And Sacrococcygeal Region
Uncomplicated Low Back Pain	ICD10CM	M48.061	Spinal Stenosis, Lumbar Region Without Neurogenic Claudication
Uncomplicated Low Back Pain	ICD10CM	M48.062	Spinal Stenosis, Lumbar Region With Neurogenic Claudication
Uncomplicated Low Back Pain	ICD10CM	M48.07	Spinal Stenosis, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M48.08	Spinal Stenosis, Sacral And Sacrococcygeal Region
Uncomplicated Low Back Pain	ICD10CM	M51.16	Intervertebral Disc Disorders With Radiculopathy, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M51.17	Intervertebral Disc Disorders With Radiculopathy, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M51.26	Other Intervertebral Disc Displacement, Lumbar Region

CODES TO IDENTIFY UNCOMPLICATED LOW BACK PAIN:			
Service	**Code Type**	**Code**	**Code Description**
Uncomplicated Low Back Pain	ICD10CM	M51.27	Other Intervertebral Disc Displacement, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M51.36	Other Intervertebral Disc Degeneration, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M51.37	Other Intervertebral Disc Degeneration, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M51.86	Other Intervertebral Disc Disorders, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M51.87	Other Intervertebral Disc Disorders, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M53.2X6	Spinal Instabilities, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M53.2X7	Spinal Instabilities, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M53.2X8	Spinal Instabilities, Sacral And Sacrococcygeal Region
Uncomplicated Low Back Pain	ICD10CM	M53.3	Sacrococcygeal Disorders, Not Elsewhere Classified
Uncomplicated Low Back Pain	ICD10CM	M53.86	Other Specified Dorsopathies, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M53.87	Other Specified Dorsopathies, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M53.88	Other Specified Dorsopathies, Sacral And Sacrococcygeal Region
Uncomplicated Low Back Pain	ICD10CM	M54.16	Radiculopathy, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M54.17	Radiculopathy, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M54.18	Radiculopathy, Sacral And Sacrococcygeal Region
Uncomplicated Low Back Pain	ICD10CM	M54.30	Sciatica, Unspecified Side
Uncomplicated Low Back Pain	ICD10CM	M54.31	Sciatica, Right Side
Uncomplicated Low Back Pain	ICD10CM	M54.32	Sciatica, Left Side
Uncomplicated Low Back Pain	ICD10CM	M54.40	Lumbago With Sciatica, Unspecified Side
Uncomplicated Low Back Pain	ICD10CM	M54.41	Lumbago With Sciatica, Right Side
Uncomplicated Low Back Pain	ICD10CM	M54.42	Lumbago With Sciatica, Left Side
Uncomplicated Low Back Pain	ICD10CM	M54.50	Low back pain, unspecified

CODES TO IDENTIFY UNCOMPLICATED LOW BACK PAIN:			
Service	**Code Type**	**Code**	**Code Description**
Uncomplicated Low Back Pain	ICD10CM	M54.51	Vertebrogenic low back pain
Uncomplicated Low Back Pain	ICD10CM	M54.5	Low Back Pain
Uncomplicated Low Back Pain	ICD10CM	M54.59	Other low back pain
Uncomplicated Low Back Pain	ICD10CM	M54.89	Other Dorsalgia
Uncomplicated Low Back Pain	ICD10CM	M54.9	Dorsalgia, Unspecified
Uncomplicated Low Back Pain	ICD10CM	M99.03	Segmental And Somatic Dysfunction Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.04	Segmental And Somatic Dysfunction Of Sacral Region
Uncomplicated Low Back Pain	ICD10CM	M99.23	Subluxation Stenosis Of Neural Canal Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.33	Osseous Stenosis Of Neural Canal Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.43	Connective Tissue Stenosis Of Neural Canal Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.53	Intervertebral Disc Stenosis Of Neural Canal Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.63	Osseous And Subluxation Stenosis Of Intervertebral Foramina Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.73	Connective Tissue And Disc Stenosis Of Intervertebral Foramina Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.83	Other Biomechanical Lesions Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.84	Other Biomechanical Lesions Of Sacral Region
Uncomplicated Low Back Pain	ICD10CM	S33.100A	Subluxation Of Unspecified Lumbar Vertebra, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.100D	Subluxation Of Unspecified Lumbar Vertebra, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.100S	Subluxation Of Unspecified Lumbar Vertebra, Sequela
Uncomplicated Low Back Pain	ICD10CM	S33.110A	Subluxation Of L1/l2 Lumbar Vertebra, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.110D	Subluxation Of L1/l2 Lumbar Vertebra, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.110S	Subluxation Of L1/l2 Lumbar Vertebra, Sequela
Uncomplicated Low Back Pain	ICD10CM	S33.120A	Subluxation Of L2/l3 Lumbar Vertebra, Initial Encounter

CODES TO IDENTIFY UNCOMPLICATED LOW BACK PAIN:			
Service	**Code Type**	**Code**	**Code Description**
Uncomplicated Low Back Pain	ICD10CM	S33.120D	Subluxation Of L2/l3 Lumbar Vertebra, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.120S	Subluxation Of L2/l3 Lumbar Vertebra, Sequela
Uncomplicated Low Back Pain	ICD10CM	S33.130A	Subluxation Of L3/l4 Lumbar Vertebra, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.130D	Subluxation Of L3/l4 Lumbar Vertebra, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.130S	Subluxation Of L3/l4 Lumbar Vertebra, Sequela
Uncomplicated Low Back Pain	ICD10CM	S33.140A	Subluxation Of L4/l5 Lumbar Vertebra, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.140D	Subluxation Of L4/l5 Lumbar Vertebra, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.140S	Subluxation Of L4/l5 Lumbar Vertebra, Sequela
Uncomplicated Low Back Pain	ICD10CM	S33.5XXA	Sprain Of Ligaments Of Lumbar Spine, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.6XXA	Sprain Of Sacroiliac Joint, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.8XXA	Sprain Of Other Parts Of Lumbar Spine And Pelvis, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.9XXA	Sprain Of Unspecified Parts Of Lumbar Spine And Pelvis, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.002A	Unspecified Injury Of Muscle, Fascia And Tendon Of Lower Back, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.002D	Unspecified Injury Of Muscle, Fascia And Tendon Of Lower Back, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.002S	Unspecified Injury Of Muscle, Fascia And Tendon Of Lower Back, Sequela
Uncomplicated Low Back Pain	ICD10CM	S39.012A	Strain Of Muscle, Fascia And Tendon Of Lower Back, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.012D	Strain Of Muscle, Fascia And Tendon Of Lower Back, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.012S	Strain Of Muscle, Fascia And Tendon Of Lower Back, Sequela
Uncomplicated Low Back Pain	ICD10CM	S39.092A	Other Injury Of Muscle, Fascia And Tendon Of Lower Back, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.092D	Other Injury Of Muscle, Fascia And Tendon Of Lower Back, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.092S	Other Injury Of Muscle, Fascia And Tendon Of Lower Back, Sequela

CODES TO IDENTIFY UNCOMPLICATED LOW BACK PAIN:			
Service	**Code Type**	**Code**	**Code Description**
Uncomplicated Low Back Pain	ICD10CM	S39.82XA	Other Specified Injuries Of Lower Back, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.82XD	Other Specified Injuries Of Lower Back, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.82XS	Other Specified Injuries Of Lower Back, Sequela
Uncomplicated Low Back Pain	ICD10CM	S39.92XA	Unspecified Injury Of Lower Back, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.92XD	Unspecified Injury Of Lower Back, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.92XS	Unspecified Injury Of Lower Back, Sequela

CODES TO IDENTIFY IMAGING STUDIES:			
Service	**Code Type**	**Code**	**Code Description**
Imaging Study	CPT	72020	Radiologic Examination Spine Single View Specify Level
Imaging Study	CPT	72040	Radiologic Examination, Spine, Cervical; 2 Or 3 Views
Imaging Study	CPT	72050	Radiologic Examination, Spine, Cervical; 4 Or 5 Views
Imaging Study	CPT	72070	Radiologic Examination, Spine; Thoracic, 2 Views
Imaging Study	CPT	72072	Radiologic Examination, Spine; Thoracic, 3 Views
Imaging Study	CPT	72074	Radiologic Examination, Spine; Thoracic, Minimum Of 4 Views
Imaging Study	CPT	72080	Radiologic Examination, Spine; Thoracolumbar Junction, Minimum Of 2 Views
Imaging Study	CPT	72081	Radiologic Examination, Spine, Entire Thoracic And Lumbar, Including Skull, Cervical And Sacral Spine If Performed (eg, Scoliosis Evaluation); One View
Imaging Study	CPT	72082	Radiologic Examination, Spine, Entire Thoracic And Lumbar, Including Skull, Cervical And Sacral Spine If Performed (eg, Scoliosis Evaluation); 2 Or 3 Views
Imaging Study	CPT	72083	Radiologic Examination, Spine, Entire Thoracic And Lumbar, Including Skull, Cervical And Sacral Spine If Performed (eg, Scoliosis Evaluation); 4 Or 5 Views
Imaging Study	CPT	72084	Radiologic Examination, Spine, Entire Thoracic And Lumbar, Including Skull, Cervical And Sacral Spine If Performed (eg, Scoliosis Evaluation); Minimum Of 6 Views
Imaging Study	CPT	72052	Radiologic examination, spine, cervical; 6 or more views
Imaging Study	CPT	72100	Radiologic Examination Spine Lumbosacral Two Or Three Views
Imaging Study	CPT	72110	Radiologic Examination Spine Lumbosacral Minimum Of Four Views
Imaging Study	CPT	72114	Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views
Imaging Study	CPT	72120	Radiologic Examination Spine Lumbosacral Bending Views Only, 2 or 3 views

CODES TO IDENTIFY IMAGING STUDIES:			
Service	**Code Type**	**Code**	**Code Description**
Imaging Study	CPT	72125	Computed Tomography, Cervical Spine; Without Contrast Material
Imaging Study	CPT	72126	Computed Tomography, Cervical Spine; With Contrast Material
Imaging Study	CPT	72127	Computed Tomography, Cervical Spine; Without Contrast Material, Followed By Contrast Material(s) And Further Sections
Imaging Study	CPT	72128	Computed Tomography, Thoracic Spine; Without Contrast Material
Imaging Study	CPT	72129	Computed Tomography, Thoracic Spine; With Contrast Material
Imaging Study	CPT	72130	Computed Tomography, Thoracic Spine; Without Contrast Material, Followed By Contrast Material(s) And Further Sections
Imaging Study	CPT	72131	Computed tomography, lumbar spine; without contrast material
Imaging Study	CPT	72132	Computed tomography, lumbar spine; with contrast material
Imaging Study	CPT	72133	Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections
Imaging Study	CPT	72141	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Cervical Without Contrast Material
Imaging Study	CPT	72142	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Cervical With Contrast Material(s)
Imaging Study	CPT	72146	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Thoracic Without Contrast Material
Imaging Study	CPT	72147	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Thoracic With Contrast Material(s)
Imaging Study	CPT	72148	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Lumbar Without Contrast Material
Imaging Study	CPT	72149	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Lumbar With Contrast Material(s)
Imaging Study	CPT	72156	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Without Contrast Material Followed By Contrast Material(s) and further sequences; cervical
Imaging Study	CPT	72157	Magnetic Resonance (eg, Proton) Imaging, Spinal Canal And Contents, Without Contrast Material, Followed By Contrast Material(s) And Further Sequences; Thoracic
Imaging Study	CPT	72158	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Without Contrast Material Followed By Contrast Material(s) and further sequences; lumbar
Imaging Study	CPT	72200	Radiologic Examination Sacroiliac Joints Less Than Three Views
Imaging Study	CPT	72202	Radiologic Examination Sacroiliac Joints Three Or More Views
Imaging Study	CPT	72220	Radiologic Examination Sacrum And Coccyx Minimum Of Two Views
Imaging Study	CPT	99457	Remote Physiologic Monitoring Treatment Management Services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes

☑ Population: Women

MCAS Measure

Breast Cancer Screening (BCS-E)

Summary of Changes to the 2025 Global Quality P4P Program Guide:

- Update to measure title
- Update to measure description

Methodology: HEDIS®

Measure Description: The percentage of Members 50-74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer any time on or between October 1, two years prior to the measurement year (2023) and December 31 of the measurement year (2025).

- The eligible population in the measure meets all of the following criteria:
  1. Members 52-74 years as of December 31 of the measurement year (2025).
  2. Continuous enrollment with IEHP from October 1, two years prior to the measurement year (2023), through December 31 of the measurement year (2025), with no more than one gap in enrollment of up to 45 days for each calendar year of continuous enrollment with IEHP. No gaps in enrollment are allowed from October 1, two years prior to the measurement year (2023), through December 31, two years prior to the measurement year (2023).

CODES USED TO IDENTIFY MAMMOGRAPHY:			
Service	**Code Type**	**Code**	**Code Description**
Breast Cancer Screening	CPT	77061	Diagnostic Digital Breast Tomosynthesis Unilateral
Breast Cancer Screening	CPT	77062	Diagnostic Digital Breast Tomosynthesis Bilateral
Breast Cancer Screening	CPT	77063	Screening Digital Breast Tomosynthesis Bilateral (list Separately In Addition To Code For Primary Procedure)
Breast Cancer Screening	CPT	77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
Breast Cancer Screening	CPT	77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
Breast Cancer Screening	CPT	77067	Screening Mammography Bilateral (Two-view Film Study Of Each Breast Including Computer-aided Detection (CAD) when performed

- 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 (2025).

4. Members who had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period (2025).
5. Members 66 years of age and older as of December 31 of measurement year (2025) with both frailty and advanced illness.

Denominator: Members 52-74 years of age who meet the criteria for the eligible population.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who had one or more mammograms any time on or between October 1, two years prior to the measurement year (2023), and December 31, of the measurement year (2025).

MCAS Measure

Cervical Cancer Screening (CCS-E)

Summary of Changes to the 2025 Global Quality P4P Program Guide:

- Update to measure title
- Update to measure description

Methodology: HEDIS®

Measure Description: The percentage of Members 21–64 years of age who were recommended for routine cervical cancer screening and who were screened for cervical cancer using either of the following criteria:

- Members ages 21-64 who had cervical cytology performed every three years.
- Members ages 30-64 who had cervical high-risk human papillomavirus (hrHPV) testing performed every five years.
- Members ages 30-64 who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing performed every five years.
- The eligible population in the measure meets all of the following criteria:
    1. Members 24-64 years of age as of December 31 of the measurement year (2025).
    2. Continuous enrollment with IEHP during the measurement year (2025) with no more than one gap in enrollment of up to 45 days.

CODES TO IDENTIFY CERVICAL CYTOLOGY:			
Service	**Code Type**	**Code**	**Code Description**
Cervical Cancer Screening	CPT	88141	Cytopathology Cervical Or Vaginal (any Reporting System) Requiring Interpretation By Physician (List separately in addition to code for technical service.)
Cervical Cancer Screening	CPT	88142	Cytopathology Cervical Or Vaginal (any Reporting System) Collected In Preservative Fluid Automated Thin Layer Preparation Manual screening under Physician supervision
Cervical Cancer Screening	CPT	88143	Cytopathology Cervical Or Vaginal (any Reporting System) Collected In Preservative Fluid Automated Thin Layer Preparation; with manual screening and rescreening under physician supervision
Cervical Cancer Screening	CPT	88147	Cytopathology Smears Cervical Or Vaginal Screening By Automated System Under Physician Supervision
Cervical Cancer Screening	CPT	88148	Cytopathology Smears Cervical Or Vaginal Screening By Automated System With Manual Rescreening Under Physician Supervision
Cervical Cancer Screening	CPT	88150	Cytopathology Slides Cervical Or Vaginal Manual Screening Under Physician Supervision
Cervical Cancer Screening	CPT	88152	Cytopathology Slides Cervical Or Vaginal With Manual Screening And Computer-assisted Rescreening Under Physician Supervision

CODES TO IDENTIFY CERVICAL CYTOLOGY:			
Service	**Code Type**	**Code**	**Code Description**
Cervical Cancer Screening	CPT	88153	Cytopathology Slides Cervical Or Vaginal With Manual Screening And Rescreening Under Physician Supervision
Cervical Cancer Screening	CPT	88164	Cytopathology Slides Cervical Or Vaginal (the Bethesda System) Manual Screening Under Physician Supervision
Cervical Cancer Screening	CPT	88165	Cytopathology Slides Cervical Or Vaginal (the Bethesda System) With Manual Screening And Rescreening Under Physician Supervision
Cervical Cancer Screening	CPT	88166	Cytopathology Slides Cervical Or Vaginal (the Bethesda System) With Manual Screening And Computer-assisted Rescreening Under Physician Supervision
Cervical Cancer Screening	CPT	88167	Cytopathology Slides Cervical Or Vaginal (the Bethesda System) With Manual Screening And Computer-assisted Rescreening Using cell selection and review Under Physician Supervision
Cervical Cancer Screening	CPT	88174	Cytopathology Cervical Or Vaginal (any Reporting System) Collected In Preservative Fluid Automated Thin Layer Preparation; screening by automated system, under physician supervision
Cervical Cancer Screening	CPT	88175	Cytopathology Cervical Or Vaginal (any Reporting System) Collected In Preservative Fluid automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision
Cervical Cancer Screening	HCPCS	G0123	Screening Cytopathology, Cervical Or Vaginal (any Reporting System), Collected In Preservative Fluid, Automated Thin Layer Preparation, Screening By Cytotechnologist Under Physician Supervision
Cervical Cancer Screening	HCPCS	G0124	Screening Cytopathology, Cervical Or Vaginal (any Reporting System), Collected In Preservative Fluid, Automated Thin Layer Preparation, Requiring Interpretation By Physician
Cervical Cancer Screening	HCPCS	G0141	Screening Cytopathology Smears, Cervical Or Vaginal, Performed By Automated System, With Manual Rescreening, Requiring Interpretation By Physician
Cervical Cancer Screening	HCPCS	G0143	Screening Cytopathology, Cervical Or Vaginal (any Reporting System), Collected In Preservative Fluid, Automated Thin Layer Preparation, With Manual Screening And Rescreening By Cytotechnologist Under Physician Supervision
Cervical Cancer Screening	HCPCS	G0144	Screening Cytopathology, Cervical Or Vaginal (any Reporting System), Collected In Preservative Fluid, Automated Thin Layer Preparation, With Screening By Automated System, Under Physician Supervision
Cervical Cancer Screening	HCPCS	G0145	Screening Cytopathology, Cervical Or Vaginal (any Reporting System), Collected In Preservative Fluid, Automated Thin Layer Preparation, With Screening By Automated System And Manual Rescreening Under Physician Supervision
Cervical Cancer Screening	HCPCS	G0147	Screening Cytopathology Smears, Cervical Or Vaginal, Performed By Automated System Under Physician Supervision
Cervical Cancer Screening	HCPCS	G0148	Screening Cytopathology Smears, Cervical Or Vaginal, Performed By Automated System With Manual Rescreening

CODES TO IDENTIFY CERVICAL CYTOLOGY:			
Service	**Code Type**	**Code**	**Code Description**
Cervical Cancer Screening	HCPCS	P3000	Screening Papanicolaou Smear, Cervical Or Vaginal, Up To Three Smears, By Technician Under Physician Supervision
Cervical Cancer Screening	HCPCS	P3001	Screening Papanicolaou Smear, Cervical Or Vaginal, Up To Three Smears, Requiring Interpretation By Physician
Cervical Cancer Screening	HCPCS	Q0091	Screening Papanicolaou Smear; Obtaining, Preparing And Conveyance Of Cervical Or Vaginal Smear To Laboratory

CODES TO IDENTIFY HPV TESTS:			
Service	**Code Type**	**Code**	**Code Description**
Cervical Cancer Screening	CPT	87624	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Human Papilloma Virus (HPV) High-risk Types (e.g., 16 18 31 33 35 39 45 51 52 56 58 59 68)
Cervical Cancer Screening	CPT	87625	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Human Papilloma Virus (HPV) Types 16 And 18 Only Includes Type 45, If Performed
Cervical Cancer Screening	CPT	87626	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), separately reported high-risk types (eg, 16, 18, 31, 45, 51, 52) and high-risk pooled result(s)
Cervical Cancer Screening	HCPCS	G0476	Infectious Agent Detection By Nucleic Acid (DNA or RNA); Human Papilloma Virus (HPV), High-risk Types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) For Cervical Cancer Screening, Must Be Performed In Addition To Pap Test (g0476)

- 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 (2025).
    4. Members who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix.

Denominator: Members 24-64 years of age who meet the criteria for eligible population.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who received a timely screening for cervical cancer.

MCAS Measure

Chlamydia Screening (CHL)

Summary of Changes to the 2025 Global Quality P4P Program Guide:

- Update to measure title

Methodology: HEDIS®

Measure Description: The percentage of women 16-24 years of age who identified as sexually active and who had at least one test for chlamydia during the measurement year (2025).

- 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 (2025).
  2. Continuous enrollment with IEHP during the measurement year (2025) 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	87810	Infectious Agent Antigen Detection By Immunoassay With Direct Optical Observation Chlamydia Trachomatis
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	87492	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Chlamydia Trachomatis Quantification
Sexually Active	CPT	87110	Culture Chlamydia Any Source
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

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	• Nonoxynol 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 Antigen 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, 2025

Numerator: Women in the denominator who were tested at least once for chlamydia during the measurement year (2025).

Timeliness of Prenatal Care (PPC)

Methodology: HEDIS®

Measure Description: The percentage of deliveries on or between October 8, 2024, and October 7, 2025, that received a prenatal care visit as a Member of IEHP in the first trimester, or on the IEHP enrollment start date or within 42 days of enrollment in the organization.

- The eligible population in this measure meets all of the following criteria:
    1. Continuous enrollment with IEHP 43 days prior to delivery through 60 days after delivery with no allowable gap.
    2. Anchor Date: Date of delivery
    3. Members who delivered a live birth on or between October 8, 2024, and October 7, 2025. Multiple births- Women who had two separate deliveries (different dates of service) between October 8, 2024, and October 7, 2025, count twice. Women who had multiple live births during one pregnancy count once.
- Members in hospice are excluded.
- Members who expire any time during the measurement year (2025).

Denominator: Deliveries on or between October 8, 2024, and October 7, 2025.

Numerator: Members in the denominator who had a prenatal care visit as a Member of IEHP in the first trimester, or on the IEHP enrollment start date or within 42 days of enrollment.

- Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit:
    - o A bundled service where the organization can identify the date when prenatal care was initiated
    - o A visit for prenatal care in the first trimester, or on the IEHP enrollment start date or within 42 days of enrollment

CODES TO IDENTIFY STAND ALONE PRENATAL VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Prenatal Visit	CPT-CAT-II	0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP]) (Prenatal)
Prenatal Visit	CPT-CAT-II	0501F	Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit) (Prenatal)

CODES TO IDENTIFY STAND ALONE PRENATAL VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Prenatal Visit	CPT-CAT-II	0502F	Subsequent prenatal care visit (Prenatal) [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (eg, an upper respiratory infection; patients seen for consultation only, not for continuing care)]
Prenatal Visit	CPT	99500	Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring
Prenatal Visit	HCPCS	H1000	Prenatal care, at-risk assessment
Prenatal Visit	HCPCS	H1001	Prenatal care, at-risk enhanced service; antepartum management
Prenatal Visit	HCPCS	H1002	Prenatal care, at risk enhanced service; care coordination
Prenatal Visit	HCPCS	H1003	Prenatal care, at-risk enhanced service; education
Prenatal Visit	HCPCS	H1004	Prenatal care, at-risk enhanced service; follow-up home visit

Postpartum Care (PPC)

Methodology: HEDIS®

Measure Description: The percentage of deliveries of live births on or between October 8, 2024, and October 7, 2025, that had a postpartum visit on or between 7 and 84 days after delivery.

- The eligible population in this measure meets all of the following criteria:
  1. Continuous IEHP enrollment 43 days prior to delivery through 60 days after delivery.
  2. Anchor Date: Date of delivery
  3. Members who delivered a live birth on or between October 8, 2024, and October 7, 2025. Multiple births- Women who had two separate deliveries (different dates of service) between October 8, 2024, and October 7, 2025, count twice. Women who had multiple live births during one pregnancy count once.
- Members in hospice are excluded.
- Members who expired any time during the measurement year (2025).

Denominator: Members who delivered a live birth on or between October 8, 2024, and October 7, 2025.

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

- Any of the following meet criteria:
  - A postpartum visit
  - Cervical cytology
  - A bundled service where the organization can identify the date when a postpartum care was rendered

CODES TO IDENTIFY STAND ALONE POSTPARTUM VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Postpartum Care	CPT	57170	Diaphragm or cervical cap fitting with instructions
Postpartum Care	CPT	58300	Insertion of intrauterine device (IUD)
Postpartum Care	CPT	59430	Postpartum Care Only Separate Procedure
Postpartum Care	CPT	99501	Home visit for postnatal assessment and follow-up care
Postpartum Care	CPT-CAT-II	0503F	Postpartum care visit (Prenatal)
Postpartum Care	HCPCS	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination
Postpartum Care	ICD10CM	Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
Postpartum Care	ICD10CM	Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Postpartum Care	ICD10CM	Z01.42	Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear
Postpartum Care	ICD10CM	Z30.430	Encounter for insertion of intrauterine contraceptive device
Postpartum Care	ICD10CM	Z39.1	Encounter for care and examination of lactating mother
Postpartum Care	ICD10CM	Z39.2	Encounter for routine postpartum follow-up

☑ Population: Child

MCAS Measure

Child and Adolescent Well-Care Visits (WCV)

Summary of Changes to the 2025 Global Quality P4P Program Guide:

- Updated acceptable visit types

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 (2025).

- Eligible population in this measure meets all of the following criteria:
  1. Ages 3-21 as of December 31 of the measurement year (2025).
  2. Continuous enrollment with IEHP throughout the measurement year (2025). No more than one gap in enrollment of up to 45 days during the measurement year (2025).

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)

CODES TO IDENTIFY WELL-CARE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
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
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	Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings

CODES TO IDENTIFY WELL-CARE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Well-Care Visit	ICD-10	Z01.419	Encounter for gynecological examination (general) (routine) 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	Z02.5	Encounter for examination for participation in sport
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 must be billed as the Primary diagnosis on encounter for the encounter to process correctly.*

Denominator: The eligible population.

- Anchor Date December 31, 2025

Numerator: Members in the denominator who had one or more well-care visits with a PCP or an OB/GYN during the measurement year (2025).

MCAS Measure

Childhood Immunizations (CIS-E) – Combo 10

Summary of Changes to the 2025 Global Quality P4P Program Guide:

- Update to measure title

Methodology: HEDIS®

Measure Description: The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); three haemophilus influenza type B (HiB); three hepatitis B (HepB); four pneumococcal conjugate (PCV); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The percentage of children 2 years of age who had one measles, mumps and rubella (MMR); one chicken pox (VZV); and one hepatitis A (HepA) vaccines on or between the child's first and second birthdays. The measure calculates a rate for each vaccine and one combination rate.

- Combo 10 includes the timely completion of the following antigens:
  - DTaP; IPV; MMR; HiB; HepB; VZV; PCV; HepA; Rotavirus; Flu
- The eligible population in this measure meets all of the following criteria:
  1. Children who turn 2 during the measurement year (2025).
  2. Continuous enrollment with IEHP 365 days prior to the child's second birthday through the Member's second birthday with no more than one gap in enrollment of up to 45 days during the 365 days prior to the child's second birthday through the Member's second birthday.

CHILDHOOD IMMUNIZATION CODE SET:			
Antigen	**Code Type**	**Code**	**Code Description**
DTaP	CPT	90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use
DTaP	CPT	90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenzae type b, and inactivated poliovirus vaccine, (DTaP-IPV/Hib), for intramuscular use
DTaP	CPT	90700	Diphtheria Tetanus Toxoids And Acellular Pertussis Vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use
DTaP	CPT	90723	Diphtheria Tetanus Toxoids Acellular Pertussis Vaccine Hepatitis B, and Inactivated poliovirus vaccine (DTaP-HepB-IPV), For Intramuscular Use
IPV	CPT	90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use

CHILDHOOD IMMUNIZATION CODE SET:			
Antigen	**Code Type**	**Code**	**Code Description**
IPV	CPT	90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenzae type b, and inactivated poliovirus vaccine, (DTaP-IPV/Hib), for intramuscular use
IPV	CPT	90713	Poliovirus Vaccine Inactivated (IPV) For Subcutaneous or Intramuscular Use
IPV	CPT	90723	Diphtheria Tetanus Toxoids Acellular Pertussis Vaccine Hepatitis B, and Inactivated poliovirus vaccine (DTaP-HepB-IPV), For Intramuscular Use
MMR	CPT	90707	Measles Mumps And Rubella Virus Vaccine (MMR) Live For Subcutaneous Use
MMR	CPT	90710	Measles Mumps Rubella And Varicella Vaccine (MMRV) Live For Subcutaneous Use
HiB	CPT	90644	Meningococcal Conjugate Vaccine, Serogroups C & Y And Hemophilus Influenzae Type B Vaccine (HiB-mency), four dose schedule, when administered to children six weeks-18 months of age, for intramuscular use
HiB	CPT	90647	Hemophilus Influenzae Type B Vaccine (HiB) Prp-omp Conjugate (Three Dose Schedule) For Intramuscular Use
HiB	CPT	90648	Hemophilus Influenzae Type B Vaccine (HiB) prp-t Conjugate (Four Dose Schedule) For Intramuscular Use
HiB	CPT	90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use
HiB	CPT	90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenzae type b, and inactivated poliovirus vaccine, (DTaP-IPV/Hib), for intramuscular use
HiB	CPT	90748	Hepatitis B And Hemophilus Influenzae Type B Vaccine (HepB-HiB) For Intramuscular Use
HepB	CPT	90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use
HepB	CPT	90723	Diphtheria Tetanus Toxoids Acellular Pertussis Vaccine Hepatitis B, and Inactivated poliovirus vaccine (DTaP-HepB-IPV), For Intramuscular use
HepB	CPT	90740	Hepatitis B Vaccine Dialysis Or Immunosuppressed Patient Dosage (Three Dose Schedule) For Intramuscular Use
HepB	CPT	90744	Hepatitis B Vaccine Pediatric/adolescent Dosage (Three Dose Schedule) For Intramuscular Use
HepB	CPT	90747	Hepatitis B Vaccine Dialysis Or Immunosuppressed Patient Dosage (Four Dose Schedule) For Intramuscular Use
HepB	CPT	90748	Hepatitis B And Hemophilus Influenzae Type B Vaccine (HepB-HiB) For Intramuscular Use
HepB	HCPCS	G0010	Administration Of Hepatitis B Vaccine
VZV	CPT	90710	Measles Mumps Rubella And Varicella Vaccine (MMRV) Live For Subcutaneous Use

CHILDHOOD IMMUNIZATION CODE SET:			
Antigen	**Code Type**	**Code**	**Code Description**
VZV	CPT	90716	Varicella Virus Vaccine Live For Subcutaneous Use
PCV	CPT	90670	Pneumococcal Conjugate Vaccine 13 Valent For Intramuscular Use
PCV	CPT	90671	Pneumococcal Conjugate Vaccine, 15 Valent (pcv15), For Intramuscular Use
PCV	CPT	90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use
PCV	HCPCS	G0009	Administration Of Pneumococcal Vaccine
HepA	CPT	90633	Hepatitis A Vaccine Pediatric/adolescent Dosage-2 Dose Schedule For Intramuscular Use
Rotavirus - Two Dose*	CPT	90681	Rotavirus Vaccine Human Attenuated Two Dose Schedule Live For Oral Use.
Rotavirus - Three Dose**	CPT	90680	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use
Flu	CPT	90655	Influenza Virus Vaccine, Trivalent (IIV3), Split Virus, Preservative Free, 0.25ml Dosage, For Intramuscular Use
Flu	CPT	90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use
Flu	CPT	90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use
Flu	CPT	90660	Influenza virus vaccine, trivalent, live (LAIV3) for intranasal use
Flu	CPT	90661	Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
Flu	CPT	90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
Flu	CPT	90673	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
Flu	CPT	90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
Flu	CPT	90685	Influenza Virus Vaccine Quadrivalent (II4V) Split Virus Preservative Free, 0.25 mL dosage, for Intramuscular Use
Flu	CPT	90686	Influenza Virus Vaccine Quadrivalent (II4V) Split Virus Preservative Free, 0.5 mL dosage, for Intramuscular Use
Flu	CPT	90687	Influenza Virus Vaccine Quadrivalent (II4V) Split Virus, 0.25 mL dosage, for Intramuscular Use
Flu	CPT	90688	Influenza Virus Vaccine Quadrivalent (II4V) Split Virus, 0.5 mL dosage, for Intramuscular Use
Flu	CPT	90689	Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25 mL dosage, for intramuscular
Flu	CPT	90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use

**Rotavirus - Two Dose: At least two doses of the two-dose rotavirus vaccine on different dates of services.*

***Rotavirus - Three Dose: At least three doses of the three-dose rotavirus vaccine on different dates of service.*

- Members who meet any of the following criteria are excluded:
    1. Members in hospice.
    2. Members who expired at any time during the measurement year (2025).
    3. Members who had a contraindication to a childhood vaccine on or before their second birthday .

Denominator: Children 2 years of age in the eligible population.

- Anchor Date: Child's 2nd birthday

Numerator: Members in denominator who show timely completion of all antigens in Combo10.

- All immunization series must be at least 14 days apart.

Developmental Screening (DEV)

Methodology: CMS Child Core Set

Measure Description: The percentage of children who are screened for the risk of developmental, behavioral and social delays using a standardized screening tool, in the 12 months before or on their first, second or third birthday in the measurement year (2025).

- Eligible population in this measure meets all of the following criteria:
    1. Children turning ages 1-3 as of December 31 of the measurement year (2025).
    2. Continuous enrollment with IEHP for 12 months prior to the child's first, second or third birthday with no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's first, second or third birthday.

Denominator: Children who turn ages 1, 2 or 3 by December 31 of the measurement year (2025).

- Anchor Date: Child's birthday in the measurement year

Numerator: Children who were screened for risk of developmental, behavioral and social delays on or before the child's first, second or third birthday.

Examples of developmental screening tools include but are not limited to:

- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Parents' Evaluation of Developmental Status (PEDS)
- Parents' Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
- Survey of Well-Being in Young Children (SWYC)

CODES TO IDENTIFY DEVELOPMENTAL SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Developmental Screening	CPT	96110	Developmental screening (e.g. developmental milestone survey, speech and language delay screen) with scoring and documentation, per standardized instrument.

Note: The Bright Futures schedule for Developmental Screening is at 9 months, 18 months and 30 months.

Lead Screening in Children (LSC)

Methodology: HEDIS®

Measure Description: The percentage of children who are 2 years of age and had one or more capillary or venous lead blood tests for lead poisoning, by their second birthday.

- The eligible population in this measure meets all the following criteria:
  1. No more than one gap in enrollment of up to 45 days during the 365 days before the child's second birthday through the child's second birthday.
  2. Continuous enrollment with IEHP 365 days before the child's second birthday through the child's second birthday.
- Members in hospice are excluded.
- Members who expire at any time during the measurement year (2025).

Denominator: Children who turn 2 years old during the measurement year (2025).

- Anchor Date: Child's second birthday.

Numerator: At least one lead capillary or venous blood test on or before the child's second birthday.

CODES TO IDENTIFY LEAD SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Lead Screening	CPT	83655	Lead

MCAS Measure

Immunizations for Adolescents (IMA-E) – Combo 2

Changes to the 2025 Global Quality P4P Program Guide:

- Update to measure title
- Update to age range in measure description

Methodology: HEDIS®

Measure Description: The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate; one tetanus, diphtheria toxoids and acellular pertussis (Tdap); and two or three doses of the human papillomavirus (HPV) vaccine on or before their 13th birthday. The measure calculates a rate for each vaccine and a combination rate.

- At least one dose of meningococcal conjugate vaccine on or between the Member's 10th and 13th birthdays.
- At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine on or between the Member's 10th and 13th birthdays.
- At least two HPV vaccines, with different dates of service on or between the Member's 9th and 13th birthdays.
  - There must be at least 146 days between the first and second dose of the HPV vaccine. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be on or after July 25.

    OR

    At least three HPV vaccines, with different dates of service on or between the Member's 9th and 13th birthdays.
- The eligible population in this measure meets all of the following criteria:
  1. Adolescents who turn 13 years of age during the measurement year (2025).
  2. Continuous enrollment with IEHP 365 days prior to the Member's 13th birthday through the Member's 13th birthday with no more than one gap in enrollment of up to 45 days during the 365 days prior to the 13th birthdays through the Member's 13th birthday.

CODES TO IDENTIFY MENINGOCOCAL:			
Antigen	**Code Type**	**Code**	**Code Description**
Meningococcal Conjugate	CPT	90619	Meningococcal Conjugate Vaccine, Serogroups A, C, W, Y, Quadrivalent Tetanus Toxoid Carrier (MenACWY-TT), For Intramuscular Use
Meningococcal Conjugate	CPT	90623	Meningococcal pentavalent vaccine, conjugated Men A, C, W, Y-tetanus toxoid carrier, and Men B-FHbp, For Intramuscular Use

CODES TO IDENTIFY MENINGOCOCAL:			
Antigen	**Code Type**	**Code**	**Code Description**
Meningococcal Conjugate	CPT	90733	Meningococcal Polysaccharide Vaccine, Serogroups A, C, Y, W-135, Quadrivalent (mpsv4), For Subcutaneous Use
Meningococcal Conjugate	CPT	90734	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diphtheria toxoid carrier (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use

CODES TO IDENTIFY TDAP:			
Antigen	**Code Type**	**Code**	**Code Description**
Tdap	CPT	90715	Tetanus Diphtheria Toxoids And Acellular Pertussis Vaccine (Tdap) When Administered To Individuals Seven Years Or Older For Intramuscular Use

CODES TO IDENTIFY HPV:			
Antigen	**Code Type**	**Code**	**Code Description**
HPV	CPT	90649	Human Papilloma Virus (HPV) Vaccine Types 6, 11, 16, 18, Quadrivalent (4vHPV), three Dose Schedule, For Intramuscular Use
HPV	CPT	90650	Human Papilloma Virus (HPV) Vaccine Types 16, 18 Bivalent (2vHPV) three Dose Schedule, For Intramuscular Use
HPV	CPT	90651	Human Papilloma Virus Vaccine 6, 11, 16, 18, 31, 33, 45, 52, 58, Nonavalent (9vHPV) two or three Dose Schedule, For Intramuscular Use

- Members who meet any of the following criteria are excluded:
    1. Members in hospice.
    2. Members who expired at any time during the measurement year (2025).

Denominator: Adolescents 13 years of age who meet all the criteria for eligible population.

- Anchor Date: Child's 13th birthday

Numerator: Members in the denominator who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday during the measurement year (2025).

- All immunization series must be at least 14 days apart.

MCAS Measure

Well-Child Visits in the First 15 Months of Life (W30)

Summary of Changes to the 2025 Global Quality P4P Program Guide:

- Updated acceptable visit types

Methodology: HEDIS®

Measure Description: The percentage of Members who turned 15 months old during the measurement year (2025) and had six or more well-child visits.

- The eligible population in this measure meets all of the following criteria:
  1. Children who turn 15 months old during the measurement year (2025).
  2. Member must be enrolled with IEHP by 31 days after birth and maintain continuous enrollment between 31 days and 15 months of age with no more than one gap in enrollment of up to 45 days.

Denominator: Members who turned 15 months old during the measurement year (2025) who meet all criteria for eligible population.

- Anchor Date: Child's 15th month birthday

Numerator: Members who received six or more well-child visits on or before the child's 15th month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the Practitioner assigned to the child.

- All visits must be at least 14 days apart.

NOTE: Well-child visits done as telehealth visits will not be accepted for the Well-Child Visits in the First 15 Months of Life measure.

CODES TO IDENTIFY WELL-CHILD VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Well-Child Visits in the First 15 Months of Life	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)
Well-Child Visits in the First 15 Months of Life	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)

CODES TO IDENTIFY WELL-CHILD VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Well-Child Visits in the First 15 Months of Life	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)
Well-Child Visits in the First 15 Months of Life	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-Child Visits in the First 15 Months of Life	CPT	99461	Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center
Well-Child Visits in the First 15 Months of Life	ICD10CM	Z00.110	Health Examination For Newborn Under 8 Days Old
Well-Child Visits in the First 15 Months of Life	ICD10CM	Z00.111	Health Examination For Newborn 8 To 28 Days Old
Well-Child Visits in the First 15 Months of Life	ICD10CM	Z00.121	Encounter For Routine Child Health Examination With Abnormal Findings
Well-Child Visits in the First 15 Months of Life	ICD10CM	Z00.129	Encounter For Routine Child Health Examination Without Abnormal Findings
Well-Child Visits in the First 15 Months of Life	ICD10CM	Z76.1*	Encounter For Health Supervision And Care Of Foundling
Well-Child Visits in the First 15 Months of Life	ICD10CM	Z76.2*	Encounter for health supervision and care of other healthy infant and child
Well-Child Visits in the First 15 Months of Life	ICD10CM	Z02.84	Encounter for child welfare exam

**Code must be billed as the Primary diagnosis on encounter for the encounter to process correctly.*

MCAS Measure

Well-Child Visits in the First 30 Months of Life (W30)

Summary of Changes to the 2025 Global Quality P4P Program Guide:

- Updated acceptable visit types

Methodology: HEDIS®

Measure Description: The percentage of children who turned 30 months old during the measurement year (2025) and had two or more well-child visits with a PCP within the 15-30 months of life.

- Eligible population in this measure meets all of the following criteria:
  1. Children who turn 30 months old during the measurement year (2025).
  2. Member must be enrolled with IEHP by 15 months after birth and maintain continuous enrollment between 15 months and 30 months of age with no more than one gap in enrollment of up to 45 days.

Denominator: Members who turn 30 months old during the measurement year (2025) who meet all criteria for eligible population.

- Anchor Date: Child's 30th month birthday (Calculate the 30th-month birthday as the second birthday plus 180 days).

Numerator: Members in the denominator who received two or more well-child visits between the child's 15 month plus 1 day and 30 months of life. The well-child visit must occur with a PCP, but the PCP does not have to be the Practitioner assigned to the child.

- All visits must be at least 14 days apart

NOTE: Well-child visits done as telehealth visits will not be accepted for the Well-Child Visits in the First 30 Months of Life measure.

CODES TO IDENTIFY WELL-CHILD VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Well-Child Visits in the First 30 Months of Life	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 one year)

CODES TO IDENTIFY WELL-CHILD VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Well-Child Visits in the First 30 Months of Life	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 one through four years)
Well-Child Visits in the First 30 Months of Life	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 one year)
Well-Child Visits in the First 30 Months of Life	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 one through four years)
Well-Child Visits in the First 30 Months of Life	ICD10CM	Z00.121	Encounter For Routine Child Health Examination With Abnormal Findings
Well-Child Visits in the First 30 Months of Life	ICD10CM	Z00.129	Encounter For Routine Child Health Examination Without Abnormal Findings
Well-Child Visits in the First 30 Months of Life	ICD10CM	Z00.2	Encounter For Examination For Period Of Rapid Growth In Childhood
Well-Child Visits in the First 30 Months of Life	ICD10CM	Z76.1*	Encounter For Health Supervision And Care Of Foundling
Well-Child Visits in the First 30 Months of Life	ICD10CM	Z76.2*	Encounter For Health Supervision And Care Of Other Healthy Infant And Child
Well-Child Visits in the First 30 Months of Life	ICD10CM	Z02.84	Encounter for child welfare exam

**Code must be billed as the Primary diagnosis on encounter for the encounter to process correctly.*

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - BMI (WCC)

Methodology: HEDIS®

Measure Description: The percentage of Members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation* during the measurement year (2025).

- The eligible population in this measure meets all of the following criteria:
    1. Members who are 3-17 years of age as of December 31 of the measurement year (2025).
    2. Continuous enrollment with IEHP in the measurement year (2025) with no more than one gap up to 45 days.
    3. An outpatient visit with a PCP or an OB/GYN during the measurement year (2025).

* Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

CODES TO IDENTIFY BMI PERCENTILE:			
Service	**Code Type**	**Code**	**Description**
BMI Percentile	ICD10	Z68.51	Body Mass Index [BMI] Pediatric, Less Than 5th Percentile For Age
BMI Percentile	ICD10	Z68.52	Body Mass Index [BMI] Pediatric, 5th Percentile To Less Than 85th Percentile For Age
BMI Percentile	ICD10	Z68.53	Body Mass Index [BMI] Pediatric, 85th Percentile To Less Than 95th Percentile For Age
BMI Percentile	ICD10	Z68.54	Body Mass Index [BMI] Pediatric, 95th percentile for age to less than 120% of the 95th percentile for age

Members who meet any of the following criteria are excluded:

1. Members in hospice.
2. Members who have a diagnosis of pregnancy any time during the measurement year (2025).
3. Members who expired at any time during the measurement year (2025).

Denominator: Members 3-17 years of age who meet all the criteria for eligible population.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who had evidence of BMI percentile documentation during the measurement year (2025).

☑ 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:

- ► Members 0 - 18.99 months, IHA must be completed within 60 days of enrollment with IEHP.
- ► Members 19 months and older, IHA must be completed within 120 days of enrollment with IEHP.

- The eligible population is newly assigned Members with an IEHP effective enrollment date of January 1, 2025 through August 31, 2025. The IHA must be provided by the age-appropriate due date.

  For example: Member enrolled in August 2025 must be seen by:
  - Member 0 - 18.99 months: October 2025 and PCP must submit encounter by November 2025.
  - Member 19 months and older: December 2025 and PCP must submit encounter by January 2026.

  NOTE: If the Member is not seen by the age-appropriate due date, please continue efforts to see the Member before 120 days have passed to meet the Department of Health Care Services' (DHCS) requirements.
- IHA visits completed during the 11 months prior to enrollment with IEHP count towards numerator compliance.

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**	**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.
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.

CODES TO IDENTIFY IHA VISITS:		
Code Type	**Code**	**Description**
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.
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

CODES TO IDENTIFY IHA VISITS:		
Code Type	**Code**	**Description**
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
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
CPT	99429	Unlisted Preven Meds Serv

CODES TO IDENTIFY IHA VISITS:		
Code Type	**Code**	**Description**
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
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

CODES TO IDENTIFY IHA VISITS:		
Code Type	**Code**	**Description**
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

Access to Care Needed Right Away (MSS)

Methodology: IEHP's Monthly Member Satisfaction Survey (MSS)

Measure Description: In the last six months, when you needed care right away, how often did you get care as soon as you needed?

- Valid response: never, sometimes, usually, always
- Target response: usually, always

Measure Support: To help identify opportunities to improve customer service, IEHP conducts a monthly Member Satisfaction Survey between June-December annually. Member survey responses are analyzed and shared at the PCP and IPA level.

Coordination of Care (MSS)

Methodology: IEHP's Monthly Member Satisfaction Survey (MSS)

Measure Description: In the last six months, how often did your Personal Doctor seem informed and up-to-date about the care you received from these Doctors or other health Providers?

- Valid response: never, sometimes, usually, always
- Target response: usually, always

Measure Support: To help identify opportunities to improve customer service, IEHP conducts a monthly Member Satisfaction Survey between June-December annually. Member Survey responses are analyzed and shared at the PCP and IPA level.

Rating of Access to Routine Care (MSS)

Methodology: IEHP's Monthly Member Satisfaction Survey (MSS)

Measure Description: In the last six months, how often did you get an appointment for a check-up or routine care at a Doctor's office or clinic as soon as you needed it?

- Valid response: never, sometimes, usually, always
- Target response: usually, always

Measure Support: To help identify opportunities to improve customer service, IEHP conducts a monthly Member Satisfaction Survey between June-December annually. Member Survey responses are analyzed and shared at the IPA level.

Potentially Avoidable Emergency Department (ED) Visits (LANE)

Methodology: IEHP has developed this measure in accordance with the New York University (NYU) research conducted on classifying emergency department utilization (https://wagner.nyu.edu/community/faculty) and the California Department of Healthcare Services (DHCS) methodology for determining Low-acuity non-emergent (LANE) visits.

Measure Description: Low-acuity non-emergent (LANE) visits are visits to an emergency department (ED) in which the condition could be treated by a physician or other health care provider in a non-emergency setting or conditions that are potentially preventable or ambulatory care sensitive.

The following steps are used to determine potentially preventable emergency room visits:

Step 1: Identify all Emergency Department (ED) visits that contain potentially preventable diagnosis codes on both the facility and professional claims in the measurement year (2025).

Step 2: The following criteria is assessed to exclude ED visits:

- ED visits that resulted in an inpatient admission or observation stay
- Members under the age of 4 or over the age of 65 on the date of service
- ED visits with evaluation & management codes 99284 and 99285

Step 3: Using the primary diagnosis code on the facility component of the ED visit, preventable percentages are assigned to each ED event to account for external factors that can influence and impact variation in ED use. These "preventable percentages" for each ED visit are summed to create a final "count" of preventable ED visits based on the primary diagnosis code on the facility component of the ED visit. The attached worksheet contains the diagnosis codes and preventable percentages assigned to each code ***(https://www.providerservices.iehp.org/en/provider-central/provider-incentive-programs/pay-for-performance-program#potentially-avoidable-emergency-department)***.

Denominator: All assigned Medi-Cal Members each month of the measurement year (2025). All monthly assigned Members are summed to create a denominator. This is also called Member Months.

Numerator: The sum of the output from Step 3 noted above for Members assigned to the IPA on the date of service. This is the final count of preventable ED visits.

Rate: (Numerator / Denominator) x 12,000

PROCESS MEASURES

Process Measures

Process measures allow IPAs to earn additional dollars based on performance in process metrics. IEHP is committed to reward IPAs who have high performance in quality metrics that assist in providing quality care to IEHP Members.

For the 2025 program year, IPAs can earn an additional PMPM up to $2.50 for the process measures listed below, for meeting the process measure goals. Please see Appendix 3 below for measure details.

APPENDIX 3: *2025 IPA Global Quality Process Measures*

2025 GLOBAL QUALITY IPA PROCESS MEASURE LIST		
Measure Name	**Goal**	**Incentive Amount (PMPM*)**
Electronic Medical Record Connections	IPA top five (5) high volume Primary Care Physicians (PCPs) electronic medical record (EMR) systems connected directly to IEHP.	$0.50
Quality Improvement Activity #1: Improving Health Outcomes	1) Establish a Quality Improvement Activity with a plan to improve health outcomes in one of the following areas: - Hemoglobin A1c Control - Controlling High Blood Pressure - Asthma Medication Ratio - Well-Child Visits in the First 0-15 Months of Life 2) Share the Quality Improvement Activity progress/status at Fall 2025 IPA Best Practice Meeting. 3) Share the Quality Improvement Activity outcomes at the Spring 2026 IPA Quality Improvement Activity Symposium.	$1.00
Quality Improvement Activity #2: Potentially Avoidable Emergency Department Visits or Potentially Preventable Admissions	1) Establish a Quality Improvement Activity with a plan to reduce inappropriate use of ER and acute care services and share plan with IEHP no later than April 30, 2025. 2) Share the Quality Improvement Activity progress/status at Fall 2025 IPA Best Practice Meeting. 3) Share the Quality Improvement Activity outcomes at the Spring 2026 IPA Quality Improvement Activity Symposium.	$1.00

**PMPM: Per Member Per Month*

APPENDIX 4: *Process Measure Overview*

Electronic Medical Record Connections

Methodology: IEHP-Defined Process Measure

Measure Description: The count of IPA Primary Care Physicians (PCPs) electronic medical record (EMR) systems connected directly to IEHP.

Denominator: Top five (5) high volume PCPs in the IPA's network, with at least 1,000 assigned IEHP Medi-Cal Members, as of June 30, 2025. IPAs should refer to eligibility data provided by IEHP, through the 834 eligibility file, to identify PCPs.

Numerator: Established EMR connections with eligible Providers within the denominator. Any EMR that has capability to connect to IEHP will be included.

- Connections will need to be established by December 1, 2025.
- Eligible EMR connections for the 2025 performance year will be identified as Providers who are high volume PCPs in the IPAs network, and are new EMR connections that were not established in the 2024 performance year.

NOTE: IEHP must have connection to the Providers EMR system throughout the time period the IPA is receiving the Electronic Medical Record Connections process measure Quality PMPM.

Quality Improvement Activity #1: Improving Health Outcomes

Methodology: IEHP-Defined Process Measure

Measure Description: Inland Empire Health Plan has made health outcomes a central area of focus in its Quality Strategy. The intent is for IPAs to develop a quality improvement activity with an emphasis on driving improvements and their root causes in the following areas:

- Hemoglobin A1c Control
- Controlling High Blood Pressure
- Asthma Medication Ratio
- Well-Child Visits in the First 0-15 Months of Life

Goal: Engage IPAs in quality improvement work focused on improving health outcomes among their IEHP Medi-Cal Members.

1. Establish a Quality Improvement Activity to improve health outcomes (including calculated baseline rate and targeted goals).
2. Share Quality Improvement Activity progress at the Fall 2025 IPA Best Practice Meeting.
3. Share outcomes with IEHP by March 31, 2026.
4. Share Quality Improvement Activity outcomes at the Spring 2026 IPA Quality Improvement Activity Symposium.

NOTE: IPA must attend and present at both the GQ P4P IPA Best Practices Symposium and the GQ P4P IPA QIA Outcomes Symposium in order to qualify for the QIA PMPM incentive.

Quality Improvement Activity #2: Potentially Avoidable ED Visits or Potentially Preventable Admissions

Methodology: IEHP-Defined Process Measure

Measure Description: As part of its rate development process, the Department of Health Care Services (DHCS) penalizes health plans that have a high rate of avoidable emergency room visits or potentially preventable admissions. The intent for this process measure is for IPAs to develop a quality improvement activity aimed at reducing avoidable emergency room visits or potentially preventable admissions among Members with diabetes or heart failure.

Goal: Engage IPAs in quality improvement work focused on reducing avoidable emergency room visits or potentially preventable admissions among their IEHP Medi-Cal Members with diabetes or heart failure.

1. Establish an improved quality improvement project (a continuation of the 2024 Quality Improvement Reducing Potentially Avoidable ED Visits or Potentially Preventable Admissions Activity) to reduce avoidable emergency room visits or potentially preventable admissions and calculate baseline rates. Share project details with IEHP.
    - By April 30, 2025
2. Share Quality Improvement Activity progress at the Fall 2025 IPA Best Practice Meeting.
3. Share outcomes with IEHP by March 31, 2026.
4. Share Quality Improvement Activity outcomes at the Spring 2026 IPA Quality Improvement Activity Symposium.

NOTE: IPA must attend and present at both the GQ P4P IPA Best Practices Symposium and the GQ P4P IPA QIA Outcomes Symposium in order to qualify for the QIA PMPM incentive.

PENALTY MEASURES

Penalty Measures

Provider payment models have been evolving away from traditional fee-for-service and moving toward payments for quality and value. Frameworks supporting alternative payment models have been developed by the Centers for Medicare and Medicaid Services (CMS) and the Department of Healthcare Services (DHCS). IEHP is committed to investing in alternative payment models that pay for quality and provide value. In the spirit of evolving our alternative payment models, IEHP includes "risk" as a component in the Global Quality P4P Program. This movement will focus on measures that:

- Are within a Provider's scope of care and influence
- Are within a Provider's control and influence
- Bring value to the organization

IEHP will be including three penalty measures in the Global Quality P4P Program for 2025:

- PCP Encounter Data Rate
- Customer Service Grievance
- Medi-Cal Managed Care Accountability Set (MCAS) Performance

Penalty measures represent processes within the PCP practice that are within the control of the Provider. These measures will be structured in a way that a Provider's performance will be compared to a pre-determined target for the measurement period. Provider performance that meets or exceeds the target will result in no penalty or "risk." Alternatively, Provider performance that falls below the established target will result in a financial penalty. The financial penalty will be taken from the Provider's incentive earnings for the same measurement period. Financial penalties will not exceed the value of the incentive earnings within the measurement period.

Financial penalties for the 2025 program year will be capped at no more than $1.00 PMPM.

Please see Appendix 5 for penalty details.

APPENDIX 5: *2025 IPA Global Quality P4P Program Penalty Measures*

2025 GQ P4P IPA PENALTY MEASURE LIST			
Measure Name	**Population**	**Goal**	**Penalty Amount**
PCP Encounter Data Rate - SPD*	All	3	$0.25
PCP Encounter Data Rate - Non-SPD*	All	2.5	
Customer Service Grievance	All	≤3.0	$0.25
Medi-Cal Managed Care Accountability Set (MCAS) Performance	All	≥75%	$0.50

*SPD: Seniors and Persons with Disabilities; Non-SPD: Non-Seniors and Persons with Disabilities

APPENDIX 6: *Penalty Measures Overview*

PCP Encounter Data Rate

Methodology: IEHP-Defined Risk Measure

Measure Description: Percentage of complete, timely and accurate encounter data submitted through standard reporting channels for all PCP services rendered to IEHP Members in the measurement year (2025).

Denominator: All assigned Medi-Cal Members each month of the measurement year (2025). All monthly assigned Members are summed to create the denominator.

Numerator: The sum of all unique PCP encounter (e.g., unique Member, Provider, date of service) in the measurement year (2025) for all assigned Members in the denominator.

Rate: A Per Member Per Year (PMPY) rate is calculated following this formula:
(Total unique PCP Encounters/Total Member Months) x 12= PMPY

Measure Support: The purpose of the IEHP PCP Encounter Data Rate measure is to ensure IEHP receives adequate PCP encounter data from IEHP-Contracted Medi-Cal Providers. Encounter data is important to performance scoring and is essential to the success of the GQ P4P Program.

Customer Service Grievance

Methodology: IEHP – Defined Risk Measure

Measure Description: IEHP strives to improve and maintain customer satisfaction for IEHP Members as defined in the IEHP Member Handbook under Member's Rights and Responsibilities: "Be treated with respect, fairness, and courtesy. IEHP recognizes your dignity and right to privacy" (Ma_22A). This measure will assess the rate of IEHPs Member dissatisfaction with their assigned Primary Care Provider (PCP) office in the measurement year (2025). The following criteria will define the Member's dissatisfaction:

Member Dissatisfaction: Member is not happy with the service received from their assigned PCP, and/or the office staff, that is not related to dissatisfaction regarding the quality of care/ medical treatment received. This includes, but is not limited to:

- Tone and manner that information is presented to the Member by the assigned PCP office staff.
- Negative verbal interactions between a Member and the assigned IEHP PCP and/or office staff.

Denominator: Total Membership in the measurement year (2025).

Numerator: Count of customer service grievances in the measurement year (2025) against the PCP and/or PCP office staff.

Exclusion Criteria: Reference to dirty carpet, color of the walls, office décor and/or anything not related to Provider/office staff and Member interaction.

Goal: Customer service grievance rate of ≤ 3.0 PTMPY

Medi-Cal Managed Care Accountability Set (MCAS) Performance

Methodology: IEHP-Defined Risk Measure

Measure Description: Percentage of Medi-Cal Managed Care Accountability Set (MCAS) measures that meet the minimum performance level (MPL) for the measurement year (2025).

Denominator: Total qualifying MCAS MPL measures.
- Provider must have at least three (3) scorable MCAS MPL measures.
- Anchor Date: December 31, 2025

Numerator: The count of MCAS measures that reach the MPL performance.

Goal: Provider must meet the MPL for at least 75% of the qualifying measures.

Measure Support: The purpose of the Medi-Cal Managed Care Accountability Set (MCAS) Performance measure is to ensure IEHPs performance is aligned with Medi-Cal Managed Care Accountability Set (MCAS) performance goals established by the Department of Health Care Services (DHCS). MCAS is a set of performance measures that DHCS has chosen to be reported by Medi-Cal Managed Care Health Plans (MCPs). Achieving the minimum performance level (MPL), at the 50th percentile, or more, will assist in IEHPs commitment to ensuring IEHP Members achieve optimal care and vibrant health.

2025 MEDI-CAL MANAGED CARE ACCOUNTABILITY SET (MCAS) MEASURES		
Domain	**Measure Name**	**Minimum Performance Level**
Clinical Quality	Asthma Medication Ratio	66%
Clinical Quality	Controlling High Blood Pressure	64%
Clinical Quality	Glycemic Status Assessment for Patients with Diabetes (<8.0%)	57%
Clinical Quality	Developmental Screening in the First Three Years of Life	35.70%
Clinical Quality	Breast Cancer Screening	53%
Clinical Quality	Cervical Cancer Screening	57%
Clinical Quality	Chlamydia Screening	56%
Clinical Quality	Timeliness of Prenatal Care	85%
Clinical Quality	Postpartum Care	80%
Clinical Quality	Child and Adolescent Well-Care Visits	52%
Clinical Quality	Childhood Immunizations - Combo 10	27%
Clinical Quality	Immunizations for Adolescents - Combo 2	34%
Clinical Quality	Lead Screening for Children	64%
Clinical Quality	Well-Child Visits First 15 Months of Life	60%
Clinical Quality	Well-Child Visits First 30 Months of Life	69%

The MPL benchmarks will change in October 2025 when the final MPLs are released by DHCS for MY 2025.

APPENDIX 7: *Historical Data Form*

HISTORICAL DATA FORM

Cover sheet **MUST** be accompanied with the *supporting medical record documentation*.

Measure Category	Test Type
Breast Cancer Screening	☐ Mammogram ☐ History of Mastectomy
Cervical Cancer Screening	☐ PAP or HPV Testing ☐ History of Total/Complete Hysterectomy [NO residual cervix]
Depression Screening for Adolescents and Adults	☐ Depression Screening ☐ Depression Screening Result
Diabetes Care	☐ HbA1c Results (in-office Point of Care Testing) ☐ Dilated Retinal Exam with Results
Wellness Visits	☐ Well Child Visits in the First 15 Months of Life ☐ Well Child Visits 3-21 Years of Age ☐ Weight Assessment and Counseling for Nutritional and Physical Activity ☐ Initial Health Appointment ☐ Immunizations Note: Immunizations submitted through the CAIR2 website (https://cair.cdph.ca.gov) do not require a Historical Data Form Submission
Colorectal Cancer Screening	☐ Colonoscopy ☐ History of Colon Cancer
Chlamydia Screening	☐ Test for Chlamydia
Prenatal Care	☐ Prenatal Care Visit in the First Trimester
Only measures listed above can be processed via Historical Data Form medical record submission	

Member Information

Member Name: _____

IEHP ID #: _____ DOB: _____

Provider Information

Provider Name: _____

IEHP Provider #: _____ Address: _____

City: _____ State: _____ Zip: _____

Provider Phone #: _____ Provider Fax #: _____

PLEASE FAX TO: (909) 477-8568

Attn: Inland Empire Health Plan - Quality Informatics [HEDIS] Department

NOTE: All Historical Data submissions for the 2025 performance year must be submitted to IEHP no later than December 31, 2025. The Historical Form should be utilized for the submission of visits, procedures, or services that cannot be submitted via claims or encounters (e.g., services received prior to IEHP Membership, historical surgical procedures, etc.).

Inland Empire Health Plan

IEHP 2025 MEDI-CAL ADULT MEMBER SATISFACTION SURVEY

SURVEY INSTRUCTIONS

- Answer each question by marking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☒ Yes ➔ ***If Yes, Go to Question 1***
☐ No

YOUR PERSONAL DOCTOR

1. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

☐ Yes
☐ No ➔ ***If No, Go to Question 14***

2. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

3. In the last 6 months, how often did your personal doctor listen carefully to you?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

4. In the last 6 months, how often did your personal doctor show respect for what you had to say?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

5. In the last 6 months, how often did your personal doctor spend enough time with you?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

6. In the last 6 months, how often did you and your personal doctor talk about all the prescribed medicines you take?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

7. In the last 6 months, when you had a scheduled visit with your doctor, did he or she have your health records or other facts about your care?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

8. In the last 6 months, did your doctor order a blood test, x-ray or other test for you?

☐ Yes
☐ No ➔ ***If No, Go to Question 10***

9. In the last 6 months, when your doctor ordered a blood test, x-ray or other test for you, how often did someone from your doctor's office give you those results?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

10. Would you send a friend to see your doctor?

- ☐ Yes
- ☐ No

11. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your "personal doctor"?

Worst personal doctor possible — Best personal doctor possible

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

CLERKS AND RECEPTIONISTS AT YOUR PERSONAL DOCTOR'S OFFICE

12. In the last 6 months, how often were clerks and receptionists at your personal doctor's office as helpful as you thought they should be?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

13. In the last 6 months, how often did clerks and receptionists at your personal doctor's office treat you with courtesy and respect?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, include the care you got in person, by phone, or by video. Do not include dental visits or care you got when you stayed overnight in a hospital.

14. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments with a specialist?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 18***

15. In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

16. How many specialists have you talked to in the last 6 months?

- ☐ None ➔ ***If None, Go to Question 18***
- ☐ 1 specialist
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 or more specialists

17. We want to know your rating of the specialist you talked to most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

Worst specialist possible — Best specialist possible

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

YOUR ACCESS TO CARE IN THE LAST 6 MONTHS

These questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

18. In the last 6 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 20***

19. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

20. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 22***

21. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

22. In the last 6 months, did you need care after normal office hours?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 25***

23. In the last 6 months, how often was it easy to get the after-hours care you thought you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

24. In the last 6 months, when you needed after-hours care, what did you do?

- ☐ Called IEHP Nurse Advice Line
- ☐ Called my personal doctor's office
- ☐ Went to the Urgent Care
- ☐ Went to the Emergency Room
- ☐ Did not get care
- ☐ Other

25. In the last 6 months, did you take any prescribed medicine?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 28***

26. In the last 6 months, how often was it easy to get your prescribed medicine?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

27. In the last 6 months, how often were your prescriptions not ready for you at the pharmacy due to an issue with IEHP's Prior Authorization process?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Don't know

28. In the last 6 months, did you try to get information or help about prescriptions from IEHP's customer service?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 31***

29. In the last 6 months, how often did IEHP's customer service give you the information or help you needed about prescription drugs?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

30. In the last 6 months, how often did IEHP's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

31. In the last 6 months, did you get care from a doctor or other health provider besides your personal doctor?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 33***

32. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

33. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

34. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

Worst health care possible — Best health care possible

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

YOUR HEALTH PLAN: INLAND EMPIRE HEALTH PLAN (IEHP)

The next questions ask about your experience with your health plan.

35. In the last 6 months, did you get information or help from IEHP's customer service?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 38***

36. In the last 6 months, how often did IEHP's customer service give you the information or help you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

37. In the last 6 months, how often did IEHP's customer service staff treat you with courtesy and respect?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

38. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

Worst health plan possible — Best health plan possible

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

ABOUT YOU

39. In general, how would you rate your overall health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

40. In general, how would you rate your <u>overall mental or emotional</u> health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

41. Have you had either a flu shot or flu spray in the nose in the past 12 months?

- ☐ Yes
- ☐ No
- ☐ Don't Know

42. Do you currently use tobacco? This includes smoking, vaping, or using chewing tobacco.

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 45***

43. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

44. Are you planning to quit using tobacco?

- ☐ Yes
- ☐ No

45. What is your current gender identity?

- ☐ Female
- ☐ Transgender Female/Transgender Girl/Transgender Woman/Male-to-Female (MTF)
- ☐ Male
- ☐ Transgender Male/Transgender Boy/Transgender Man/Female-to-Male (FTM)
- ☐ Non-binary
- ☐ Other: Prefer to self-describe:

  _____
- ☐ Prefer not to say

46. What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

47. Are you of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino
- ☐ No, Not Hispanic or Latino

48. What is your race? Mark one or more.

- ☐ White
- ☐ Black or African-American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Other

49. How would you like to get health information from your health plan about how to stay healthy? Select all that apply.

- ☐ Email
- ☐ Text
- ☐ Mobile application
- ☐ Website
- ☐ Social media (e.g., Facebook, Instagram, Twitter)

50. Some health plans help with nonmedical concerns, like housing, food, financial, and social isolation issues. In the last 6 months, did you talk with your personal doctor or someone from your health plan about getting help for any of these issues?

- ☐ Yes
- ☐ No

51. Did someone help you complete this survey?

- ☐ Yes
- ☐ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

52. How did that person help you? (*Mark one or more*)

- ☐ Read the questions to me
- ☐ Wrote down the answers I gave
- ☐ Answered the questions for me
- ☐ Translated the questions into my language
- ☐ Helped in some other way

Thank you for participating in our survey!
Please mail the survey back in the enclosed postage-paid, self-addressed reply envelope or send to:
Press Ganey • P.O. Box 7315
South Bend, IN 46699-0488

If you have any questions, please call 1-888-797-3605.

APPENDIX 9: *2025 IPA Global Quality P4P IPA Work Plan*

2025 IPA Quality Work Plan

Organizational Leadership: Key Leadership Support for Clinical Quality Improvement	
Item Number	Quality Program Elements
1	Which positions are responsible for the implementation and outcomes of the quality program? (Include names, titles, and departments of those responsible.)
2	Which Committee(s) review and approve quality program implementation, outcomes, interventions, and evaluations?
3	Describe how the position(s) and Committee(s) play a role in your organizations Quality program.
4	Describe the process to monitor and oversee quality programs.

Priority Measures Clinical Quality Domain: Quality Improvement Activities	
Item Number	Quality Program Elements
5	Identify the Organization's clinical quality priority measures for 2025.

Access Domain: Quality Improvement Activities	
Item Number	Quality Program Elements
6	Potentially Avoidable Emergency Department (ED) Visits

Patient Experience Domain: Quality Improvement Activities	
Item Number	Quality Program Elements
7	Coordination of Care
	Access to Routine Care
	Access to Care Needed Right Away
8	Office Staff and Physician education programs to improve patient experience
	Office Staff and Physician recognition programs to reward offices that are high performing in the area of patient experience

IPA Process Measure Domain	
Item Number	Quality Program Elements
9	Quality Improvement Activity #1: Improving Health Outcomes • Hemoglobin A1c Control • Controlling High Blood Pressure • Asthma Medication Ratio • Well-Child Visits in the First 0-15 Months of Life
10	Quality Improvement Activity #2: Potentially Avoidable ED Visits or Potentially Preventable Admissions • Reducing Potentially Avoidable ED Visits • Reducing Potentially Preventable Admissions
11	Electronic Medical Record Connections

Medi-Cal Managed Care Accountability Set (MCAS) Focus	
Item Number	Quality Program Elements
12	Please share any specific efforts towards any Medi-Cal Managed Care Accountability Set (MCAS) Performance measures. Please include measure names.

Provider & Member Engagement Domain	
Item Number	Quality Program Elements
13	Office and Practitioner Programs: Provider education programs and/or sharing of Quality Improvement and Best Practices between Providers
	Office Staff/Practitioner Recognition Programs for High Performance

Data Quality Domain	
Item Number	Quality Program Elements
14	Encounter Data (ENC) performance rates and validation for GQP4P measures: • Encounter Data Gate
	• SPD
	• Non-SPD
15	Monthly Submissions and Tracking of Capitated Provider-Level Encounters (error rates, PMPY benchmarks, chart audits, data completeness (capitated vendor), etc.: • Encounter Validation Report (EVR)
	• PCP Level Reports
	• Capitated Vendors
16	Leveraging health plan data: • Care Gap Rosters
17	Provider Support: • Submitting into CAIR2 system • Responding to grievance inquiries • Connecting to Manifest MedEx
18	Supplemental Data Submission to IEHP (if applicable): • Collaboration with IEHP • IPA Contact • Timeline for Submissions • Submission of Complete Lab Results Data • IEHP Supplemental Data Template

APPENDIX 10: *Supplemental Claim File Data Dictionary*

The Claim file contains claims for medical services. It may also contain lab services that do not have an associated result, pharmaceuticals administered in the practitioners office (usually documented by J codes in the CPT Field), and medical encounter data. The Claim file should contain one record per unique claim line and include at least one code (ICD, HCPCS, CPT, CVX).

SUPPLEMENTAL CLAIM FILE DATA DICTIONARY			
Field Name	**Data Type**	**File Order**	**Notes**
Measure_ Submeasure	Text (80)	1	HEDIS Measure or Submeasure intended to be impacted (required field)
MemberKey	Text (14)	2	IEHP Member ID (required field)
MemberFirstName	Text (50)	5	Member First Name (required field)
MemberLastName	Text (50)	6	Member Last Name (required field)
Member DOB	Date	7	The member Date of Birth in MM/DD/YYYY format (required field)
ProviderKey	Text (25)	8	The rendering provider's NPI (required field)
ClaimNumber	Text (80)	9	Used to identify the claim source for Primary Source Verification
DOS	Date	10	The beginning Date of Service for the claim in MM/DD/YYYY format (required field)
DOSThru	Date	11	The ending Date of Service for the claim in MM/DD/YYYY format
RxProviderFlag	Bit	12	Indicates that the rendering Provider has prescribing privileges for the MCO patients. Valid values are 0 (no), or 1 (yes)
CVX	Text (3)	12	A standard CVX code denoting a vaccination.
ICD10DxPri	Text (7)	13	ICD-10 diagnosis codes should contain all available alphanumeric code. Do not include the decimal. For example, V39.00XS should be coded as V3900XS
ICD10DxSec1	Text (7)	14	
ICD10DxSec2	Text (7)	15	
ICD10DxSec3	Text (7)	16	
ICD10DxSec4	Text (7)	17	
ICD10DxSec5	Text (7)	18	
ICD10DxSec6	Text (7)	19	
ICD10DxSec7	Text (7)	20	ICD-10 diagnosis codes should contain all available alphanumeric code. Do not include the decimal. For example, V39.00XS should be coded as V3900XS
ICD10DxSec8	Text (7)	21	
ICD10DxSec9	Text (7)	22	
ICD10DxSec10	Text (7)	23	
PCPFlag	Bit	24	Indicator for whether the claim provider serves as a PCP for the health plan. Refers to the provider's contractual relationship to the plan, rather than medical specialty. Valid values are 0 (no), or 1 (yes) (required field)
HCFAPOS	Text (2)	25	
HCPCSPx	Text (5)	28	

SUPPLEMENTAL CLAIM FILE DATA DICTIONARY			
Field Name	**Data Type**	**File Order**	**Notes**
HCPCSMOD	Text (2)	29	
CPTPx	Text (5)	30	Level II CPT Codes are supported by HEDIS and should be placed in the same field as other CPT procedure codes
CPTMOD	Text (2)	31	
ICD9Px1	Text (4)	32	ICD-9 procedure codes should contain all available digits (including all preceding zeros). Do not include the period that follows the third digit. With the introduction of ICD-10 code set, IEHP will continue to support the ICD-9 code set as there are historical claims that rely on these codes (for HEDIS we recommend 3-4 years of historical claims data) in order to accurately calculate HEDIS rates.
ICD9Px2	Text (4)	33	
ICD9Px3	Text (4)	34	
ICD9Px4	Text (4)	35	
ICD9Px5	Text (4)	36	
ICD9Px6	Text (4)	37	
ICD9Px7	Text (4)	38	
ICD9Px8	Text (4)	39	
ICD9Px9	Text (4)	40	
ICD9Px10	Text (4)	41	
ICD10Px1	Text (7)	42	ICD-10 procedure codes should contain all available alphanumeric code. Do not include the decimal. For example, V39.00XS should be coded as V3900XS
ICD10Px2	Text (7)	43	
ICD10Px3	Text (7)	44	
ICD10Px4	Text (7)	45	
ICD10Px5	Text (7)	46	
ICD10Px6	Text (7)	47	
ICD10Px7	Text (7)	48	
ICD10Px8	Text (7)	49	
ICD10Px9	Text (7)	50	
ICD10Px10	Text (7)	51	
ProviderType	Text (4)	52	Use values in ProviderType column in the Provider Type Crosswalk Tab
POS	Text (2)	53	Place of Service. Also automatically built using a cross-reference. Valid values are: BC (Birthing Center), DN (Day/Night Hospitalization), ER (Emergency Room), IA (Inpatient Acute), IN (Inpatient Non-Acute), LA (Laboratory), OA (Outpatient/ Ambulatory), OC (Office/Clinic), OT (Other), RM (Mail Order Prescription Drugs), RR (Retail Pharmacy) (required field)
SubmitterName	Text (80)	54	Name of IPA or Provider Group. Required if submitting on behalf of more than one health center or provider group. Can be left blank if only a single submitter.

Supplemental Lab Claim File Data Dictionary

The LabClaim file contains claims for laboratory services and allows lab results to be stored. The LabClaim file should contain one record per unique lab service claim and include at least one code (LOINC, HCPCS, CPT, SNOMED).

SUPPLEMENTAL LAB CLAIM FILE DATA DICTIONARY			
Field Name	**Data Type**	**File Order**	**Notes**
Measure_ Submeasure	Text (80)	1	HEDIS Measure or Submeasure intended to be impacted (required field)
MemberKey	Text (30)	2	IEHP Member ID (required field)
MemberFirstName	Text(50)	5	Member First Name (required field)
MemberLastName	Text (50)	6	Member Last Name (required field)
ProviderKey	Text (25)	3	The rendering provider's NPI (required field)
Member DOB	Date	7	The member Date of Birth in MM/DD/YYYY format (required field)
ClaimNumber	Text (80)	5	Used to identify the claim source for Primary Source Verification
DOS	Date	6	The Date of Service for the claim in MM/DD/YYYY format (required field)
CPTPx	Text (5)	7	Level II CPT Codes are supported by HEDIS and should be placed in the same field as other CPT procedure codes
LOINC	Text (7)	8	LOINC codes must contain the dash character that precedes the final digit
HCPCSPx	Text (5)	9	Used for medical services, that comes in through lab claims. Only one HCPCS code per claim line is allowed. If the claim contains multiple HCPCS codes, load them as separate claims
HCPCSMod	Text (2)	10	
SNOMED	Text (25)	11	Systematized nomenclature of medicine
Result	Decimal(28,10)	12	Used to document numeric lab results
PosNegResult	Bit	13	Used to document positive/negative lab results. Valid values are 0 (negative), or 1 (positive)
SubmitterName	Text (80)	14	Name of IPA or Provider Group. Required if submitting on behalf of more than one health center or provider group. Can be left blank if only a single submitter.

APPENDIX 11: *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, Asthma Management, Behavioral Health, Cardiovascular Disease Management, Child Preventive Health, Diabetes Management, Adult Immunizations, Pediatric Immunizations, Patient Experience, Perinatal Care, and Social Needs.

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 Immunizations	Member	Adult Immunization Brochure	Brochure educating on vaccines recommended for adults, their importance, and how they work.
Adult Immunizations	Provider	Recommended Immunization Schedule	CDC Adult Immunization Schedule.
Adult Immunizations	Provider	Vaccine Hesitancy Among Pregnant People	Center for Disease Control and Prevention report on common themes impact vaccine confidence and ways to address/improve vaccine confidence in pregnant people.
Adult Immunizations and Pediatric Immunizations	Member	Vaccine Information Statements (VISs)	CDC Vaccine Information Statements (VIS's) for current recommended vaccines available for children, adolescents and adults.
Adult Immunizations and Pediatric Immunizations	Member	Should you get the flu shot?	Shared decision-making guide to help Members choose whether or not to receive a flu vaccine.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Adult Immunizations and Pediatric Immunizations	Provider	CAIR2 Resource Guide	FAQs for IEHP Providers regarding CAIR2 information such as account set-up, troubleshooting, functionality, contacts, and more.
Adult Immunizations and Pediatric Immunizations	Provider	Vaccinate with Confidence	Centers for Disease Control and Prevention strategic framework to strengthen vaccine confidence and prevent outbreaks in the United States.
Adult Preventive Health	Member	Interactive Self-Management Tools	Online interactive modules on various health topics such as Healthy Weight, Healthy Eating, and Physical Activity available on the IEHP Member Portal.
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	Cancer Screening Resources	IEHP Cancer 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	Member	RadNet Online Appointments (myradiologyconnectportal.com)	Online scheduling service to schedule a mammogram through RadNet locations.
Adult Preventive Health	Member	Pap and HPV tests: What to Expect	Handout explaining the Pap test and the HPV (human papillomavirus) test. In English and Spanish.
Adult Preventive Health	Member	The Wisdom Study	The WISDOM Study (Women Informed to Screen, Depending on Measures of risk) is helping to end confusion about mammograms. Medical researchers from University of California need study volunteers, specifically women ages 40 to 74 years old who have not had breast cancer or DCIS (ductal carcinoma in situ). Study participants will: - Find out about their risk for breast cancer. - Get clarification on screening guidelines for them, their sister, daughter, and future generations. - Participate mostly from home (No extra medical visits required). - Help medical researchers discover the best guidelines for mammogram.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
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	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	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 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 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.
Adult Preventive Health, Cardiovascular Disease Management and Diabetes Management	Member	Healthy Heart	An educational guide for Members on understanding cardiovascular event risk and heart health.
Asthma Management	Member	Staying Healthy With Asthma Booklet	Workbook to help Members learn how to manage their asthma.
Asthma Management	Member	Controlling Asthma	Booklet with information on asthma symptoms, triggers and treatments.
Asthma Management	Member	Breathe Well, Live Well class at Community Resource Centers	Link to the IEHP website to find a class.
Asthma Management	Member	How We Can Protect Our Children from Secondhand Smoke	A guide from the Centers for Disease Control and Prevention (CDC) on secondhand smoke.
Asthma Management	Provider	IEHP Formulary	Document including which prescription drugs and over-the-counter drugs are covered by IEHP DualChoice.
Asthma Management	Provider	IEHP Academic Detailing	Information about academic detailing offered to Providers about asthma medication. Contact PharmacyAcademicDetailing@iehp.org.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Asthma Management	Provider	Asthma Care Quick Reference	Guidelines from the National Asthma Education and Prevention Program.
Asthma Management	Provider	GINA Pocket Guide 2023	Pocket Guide for Asthma Management and Prevention from the Global Initiative for Asthma.
Asthma Management	Provider	Transformation of Medi-Cal: Community Supports	Fact Sheet on Community Supports including Asthma Remediation. With a Provider referral, eligible Members with asthma can receive physical modifications to their home to avoid acute asthma episodes due to environmental triggers like mold. Modifications can include filtered vacuums, dehumidifiers, air filters, and ventilation improvements.
Asthma Management and Diabetes Management	Provider	HCPCS Coding Options for ECM and Community Supports	Coding to use to refer eligible Members to Community Supports for Asthma Remediation, Medically-Supportive Food or Medically Tailored Meals.
Asthma Management and Diabetes Management	Provider	Community Support: Improved Referral Submission Process	Instructions for referring eligible Members to Community Supports for Asthma Remediation Services and Medically-Supportive Food or Medically Tailored Meals within the Provider portal.
Behavioral Health	Member	IEHP Mental Health Resources	Information on contacting Behavioral Health Care Managers to assist Members with referrals and coordination of care and walk-in psychiatry clinics.
Behavioral Health	Member	Teen Mental Health Guide	Booklet provides age-appropriate information on common mental health disorders, warning signs and treatment options.
Behavioral Health	Member	Stress management, relaxation, and mindfulness classes at the Community Resource Centers in Victorville, Riverside, and San Bernardino	Classes that provide Members with evidence-supported strategies and activities to relieve stress and anxiety and to improve relaxation. Refer Members to register for an upcoming class.
Behavioral Health	Member	Interactive Self-Management Tools	Online health appraisal screening tool within the Member Portal with educational modules on Healthy Eating, Depression, Healthy Weight, Managing Stress, Physical Activity, Smoking Cessation, and At-Risk Drinking.
Behavioral Health	Member	Smoking Cessation resources	Apps and resources to help Members stop smoking.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Behavioral Health	Member	988 Suicide and Crisis Lifeline	National Suicide and Crisis Hotline/Textline in English and Spanish. Includes LGBTQI-specific help.
Behavioral Health	Member	Action Plan for Depression and Anxiety During Pregnancy and After Birth	Includes warning signs and actions to take for moms who are facing depression and anxiety during pregnancy.
Behavioral Health	Member	Postpartum Support International	Includes online support groups.
Behavioral Health	Provider	Edinburgh Postnatal Depression Screening Tool in English and Spanish	A screening tool developed to identify women who may have postpartum depression.
Behavioral Health	Provider	Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder Assessment (GAD-7) in multiple languages	Tools for assessing depressive and anxiety symptoms in individuals ages 18 and older.
Behavioral Health	Provider	PHQ-9 Modified for Adolescents (PHQ-A)	Tool for assessing the severity of depressive disorders and episodes in children ages 11–17.
Behavioral Health	Provider	Drug and Alcohol Use Screening and Counseling Resources	A page of helpful resources for Providers to use with members whose alcohol and substance use may be negatively impacting their health and quality of life.
Behavioral Health	Provider	Harm Reduction Supplies	Inland Empire Harm Reduction provides fentanyl test strips, Narcan, safe sex kits, and other harm reduction supplies free of charge. Will deliver to people who are unhoused.
Behavioral Health	Provider	Depression Resources	Links to clinical guidelines for screening and managing depression
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	AAFPHypertensionGuideline.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.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Child Preventive Health	Member	Teen Health Guide	Booklet provides age-appropriate information on reproduction, birth control methods, and sexually transmitted infections.
Child Preventive Health	Member	Blood Lead Testing Brochure	Member brochure detailing the importance of having a child tested for lead and what to expect.
Child Preventive Health	Member	Topical Fluoride Brochure	Member brochure explaining what a fluoride treatment is and its benefits.
Child Preventive Health	Member	Dental Health for Kids and Teens	Information about oral hygiene and how to find a dental provider.
Child Preventive Health	Member	Medi-Cal for Kids & Teens	Information on preventive care services for IEHP Medi-Cal Members and what services are included.
Child Preventive Health	Member	Wellness Journey - Your baby's 1st Year	Member booklet detailing what to expect for baby's preventive care during their first year of life.
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	Member	Developmental Screening	IEHP resource page on Developmental Screening explaining assessment tool as a way for caregivers to monitor their child's growth and development.
Child Preventive Health	Member	Medi-Cal Dental Coverage	Information on Medi-Cal dental coverage including what is covered and the importance of dental insurance.
Child Preventive Health	Member	Smile, California	Medi-Cal Dental website to learn about covered services and finding a dentist.
Child Preventive Health	Member	Fluoride Varnish: What Parents Need to Know	American Academy of Pediatrics Parenting Website with information on the importance of fluoride varnish.
Child Preventive Health	Provider	Caries Risk Assessment, Fluoride Varnish, and Counseling	Smiles for Life oral health curriculum including the benefits, appropriate safety precautions, and dosing for fluoride, as well as how to apply fluoride varnish.
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.
Child Preventive Health	Provider	Bright Futures/AAP Periodicity Schedule	Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
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	Oral Health Coding Fact Sheet for PCPs	American Academy of Pediatrics Oral Health Coding Fact Sheet for Primary Care Physicians.
Child Preventive Health	Provider	Smile California Primary Care Physician Toolkit	List of Provider resources on oral health and references for educational materials.
Child Preventive Health	Provider	Oral Health Practice Tools	American Academy of Pediatrics website providing resources on how to incorporate oral health into a Provider practice.
Child Preventive Health	Provider	Campaign for Dental Health	American Academy of Pediatrics website with resources on how to address fluoride with Members and Member materials.
Child Preventive Health and Pediatric Immunizations	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 and Pediatric Immunizations	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, and Immunizations for Adolescents.
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. Available in English and Spanish.
Diabetes Management	Member	Staying Healthy With Diabetes	Booklet to help Members with diabetes self-management.
Diabetes Management	Provider	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	"Prescription" for Diabetes Prevention Program	Information about the Diabetes Prevention Program to hand to patients so that they can self-refer.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Diabetes Management	Provider	Diabetes Standards of Care 2025	GuidelineCentral®
Diabetes Management	Provider	Transformation of Medi-Cal: Community Supports	Fact Sheet on Community Supports including Medically-Supportive Food/ Medically Tailored Meals. With a Provider referral, eligible Members with diabetes can receive deliveries of nutritious, prepared meals and healthy groceries to support their health needs. Members also receive vouchers for healthy food and/or nutrition education.
Patient Experience	Member	Urgent Care Clinics	A directory search tool of all Urgent Care Clinics within the IEHP network.
Patient Experience	Member	ER vs. Urgent Care Clinic	A guide for Members on when to visit the Emergency Room versus an Urgent Care Clinic.
Patient Experience	Member	24-Hour Nurse Advice Line	24-hour nurse advice offered by IEHP.
Patient Experience	Member	IEHP - Care Options : How to Get Care	Information on ways to get care including primary care, specialty care, and medications.
Patient Experience	Provider	Serve Well Customer Service Toolkit	A Provider toolkit on how to provide outstanding customer service to Members.
Pediatric Immunizations	Member	Immunization Timing	Handout that provides a visual of what immunizations are needed from birth to 18 years of age.
Pediatric Immunizations	Provider	CDC Child & Adolescent Immunization Schedule	CDC Child and Adolescent Immunization Schedule by Age recommendations for ages 18 or younger.
Pediatric Immunizations	Provider	Common Immunization Questions from Parents (aap.org)	American Academy of Pediatrics Parenting Website with information on recommended immunizations and common questions.
Perinatal Care	Member	IEHP Pregnancy & Postpartum	Information for IEHP Members on resources and services available to maternal population including doula services, Maternal Health program, breastfeeding support, and pregnancy & postpartum class series.
Perinatal Care	Member	My Job and My New Baby	A booklet which outlines the rights of new parents who live in California.
Perinatal Care	Member	Start Well Booklet	Informational booklet on resources during pregnancy by trimester and throughout pregnancy.
Perinatal Care	Member	Labor and Birth Planner	Planner resource to help Member make labor and birth choices prior to delivery.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Perinatal Care	Provider	Guidelines for Perinatal Care 8th Edition	An educational resource to aid clinicians in providing obstetric and gynecologic care, developed through efforts by the American Academy of Pediatrics (AAP) Committee on Fetus and Newborn and the American College of Obstetricians and Gynecologists (ACOG).
Perinatal Care	Provider	Provider Perinatal Resources and Forms	Perinatal risk assessment forms including Depression Screening, California Prenatal Screening Program, and Initial Perinatal Risk Assessment Form.
Social Needs	Member	ConnectIE	Website to search for free or reduced cost services in the Inland Empire like medical care, food, job training and more.
Social Needs	Member	ECM Brochure	Brochure outlining IEHP services available through Enhanced Care Management for specific Members with health or behavioral health needs and social needs.
Social Needs	Provider	Social Needs Screening Tool	Social Needs Screening Tool from The EveryONE Project.
Social Needs	Provider	Social Needs Screening Tool	Social Needs Screening Tool from Center for Medicare and Medicaid Innovation.
Social Needs	Provider	Community Supports	Additional information about services covered under the California medical State Plan.

*The referenced electronic links provided in this resource are informational only. They are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by Practitioners, considering each Member's needs on an individual basis. Best practice guideline recommendations and assessment tools apply to populations of patients. Clinical judgment is necessary to appropriately assess and treat each individual Member.

NOTES

IEHP
Inland Empire Health Plan

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PROVIDER RELATIONS TEAM

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