2025

GLOBAL QUALITY P4P (FOR PCPs)

Pay for Performance (P4P) Program Technical Guide

Inland Empire Health Plan

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Published: August 18, 2025

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PROGRAM OVERVIEW

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

This year's GQ P4P Program continues to provide financial rewards to PCPs for improving health care quality across multiple domains and measures. The 2025 Global Quality P4P Program includes core measures, a process measure 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 PCP 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 PCPs to attend IEHP Provider P4P meetings that are held throughout the year to support your efforts to maximize earnings in this program.

If you would like 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?

Three measures were Added

Core Measures

- Adult Hepatitis B Vaccine
- Rating of Access to Routine Care

Penalty Measures

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

Three measures were Revised

Core Measures

- Adult Zoster Vaccine
- Adult Pneumococcal Vaccine

Process Measures

- Manifest MedEx (MX) Connectivity

Sixteen 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
- Member Satisfaction Survey – Medical Assistance with Smoking Cessation Advising Smokers to Quit

Process Measures

- Provider Diversity Equity Inclusion Survey

Eligibility and Participation

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

- Must be active and contracted with IEHP for Medi-Cal and have active assigned Medi-Cal Members at the time of payment.
- Have at least 200 Medi-Cal Members (per Provider location), assigned as of July 2025 and December 2025.
- Have at least 20 Members in the denominator as of December 2025 for each quality measure to qualify for scoring.
- Quality Score must be 1.0 or higher in order to qualify for incentive payments.
- Have at least three quality measures that meet minimum denominator requirements in order for a global quality score to be calculated.
- Provider must be connected to CAIR2 (must enter immunizations into the registry and use to look up prior immunizations given to assigned patients) by July 1, 2025.

PCP enrollment into the GQ P4P program is automatic once the six criteria above have been met.

☑ Minimum Data Requirements

Encounter Data

Encounter data is foundational to performance measurement and is essential to succeed in the GQ P4P Program. Complete, timely and accurate encounter data should be submitted through normal reporting channels for all services rendered to IEHP Members. Please use the appropriate codes listed in Appendix 2 to meet measure requirements.

Lab Results

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

Immunizations

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

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 Providers reach each level of higher performance. The 2025 GQ P4P Program incentive pool is $124 million for PCPs. 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 PCP performance, payment methodologies may be adjusted to ensure that the 2025 program year costs do not exceed this $124 million pool for the PCP Program.

CORE MEASURES

Performance Measures

Appendix 1 provides a list of the 30 measures in the 2025 GQ P4P Core Program and includes 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
- 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
- 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 undergo 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 Measures:

- 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 four 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
- Rating of Personal Doctor

Scoring Methodology

Payments within the core program will be awarded to PCPs 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 PCP. The eligible population is defined as the set of Members who meet the denominator criteria specified in each measure by NCQA. Members in the eligible population are attributed to the assigned PCP on each measure's anchor date, as defined within each measure. Members contribute to a PCP'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 PCP during the measurement year and who remain enrolled with IEHP and the PCP 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 PCP based on the most recent encounter that qualified the Member to be eligible for the survey. A Member is eligible to receive only one survey per calendar year.

Payment Methodology

PCP 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 1.5 = one and half points, Tier 2 = two points, Tier 2.5 = two and half points, Tier 3 = three points, Tier 4 = four points) for each measure.

Providers who have at least three quality measures that meet the minimum denominator size (n = 20) 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, blood pressure control, and childhood immunizations) are given a weight of 3

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 Membership] x [GQ P4P Payment Multiplier] / [Total Medi-Cal Member Months]) + Bonus Bundles + Process Measure - Penalty Measures = GQ P4P PMPM Bonus

The payment multiplier will be determined based on the Providers' final 2025 Quality Performance Score:

GLOBAL QUALITY P4P PAYMENT MULTIPLIER*					
2025 Quality Score	1.00 – 1.49	1.50 – 1.99	2.00 – 2.49	2.50- 2.99	≥ 3.00
Payment Multiplier	47.50	49.00	50.00	52.00	55.00

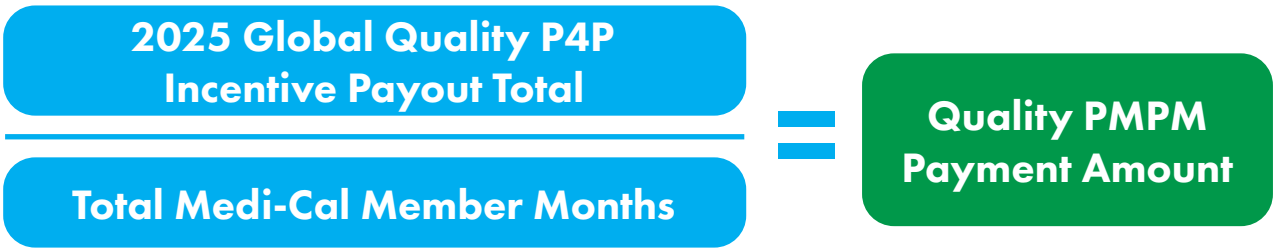
** The GQ P4P payment multiplier is subject to change based on Network performance and budget limits. The GQ P4P payment multiplier value displayed in the Interim Reports may not be the final value used in determining final Quality PMPM payment amounts.*

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

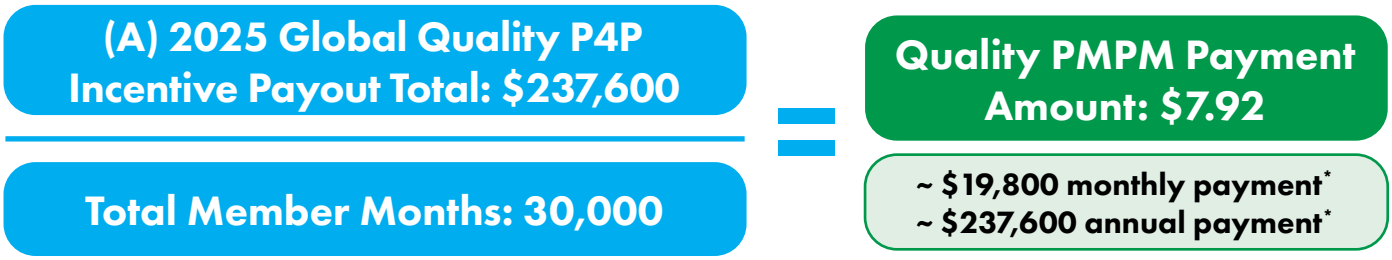
PROVIDER TYPE	MAXIMUM QUALITY SCORE	MAXIMUM QUALITY PMPM
Family Practice	3.79	$20.12
Internal Medicine	3.72	$19.80
Pediatrics	3.76	$19.98

PCP PMPM Quality Payment Methodology

From July 2026 – June 2027, PCPs will receive a monthly Quality PMPM payment based on their 2025 GQ P4P performance using the following formula:



PCP payment example: *PCP with monthly average of 2,500 Members (30,000 Member Months) and 2.0 GQ Quality Score*



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

NOTE: Members with Other Health Coverage will be removed from the measure denominators prior to the final payment calculation.

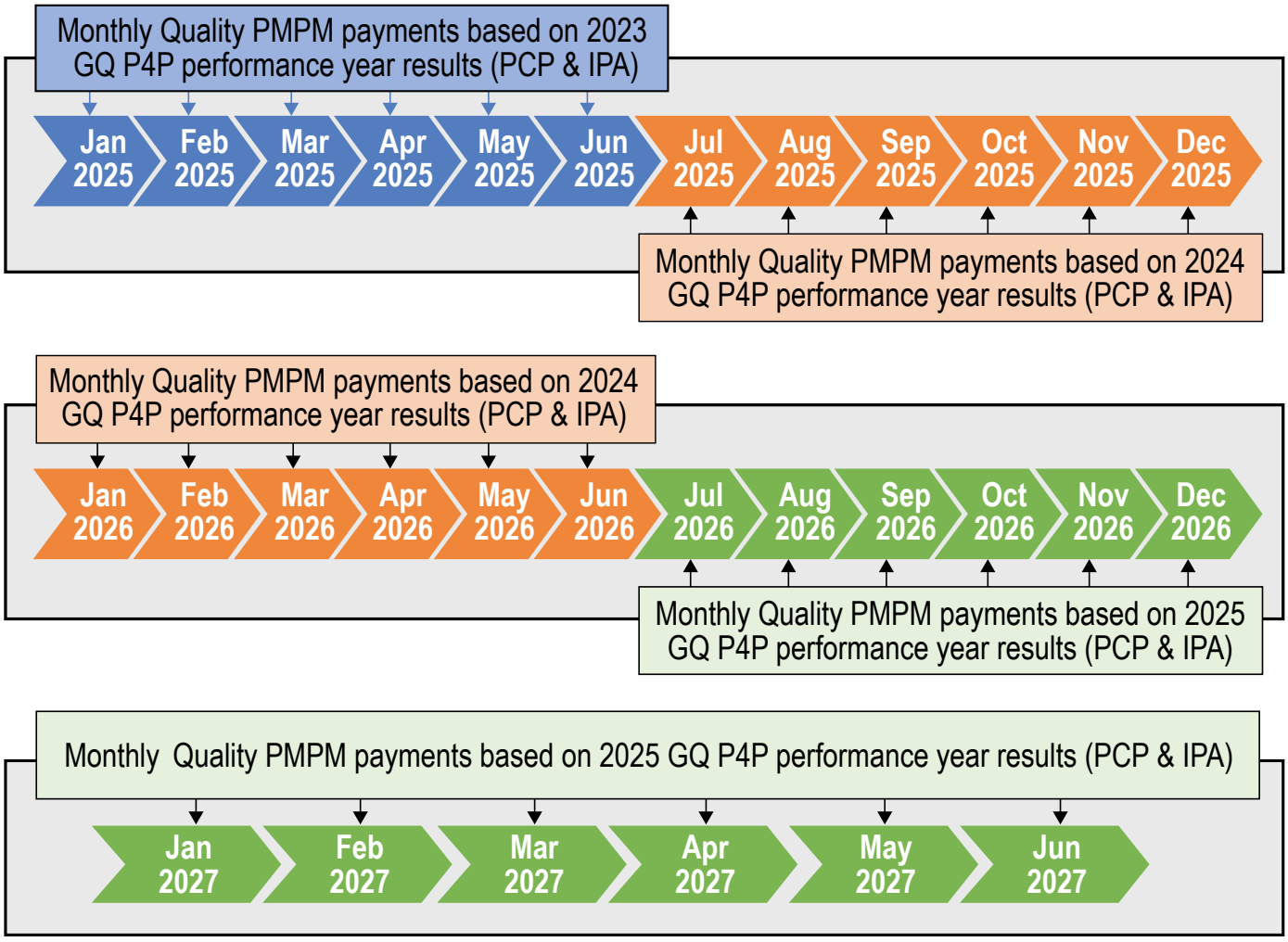
Reporting Timeline

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	7/1/2025	7/1/2025	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



NOTE: Quality PMPM payments are based on active assigned IEHP Medi-Cal members as of the month of payment. Providers must have active assigned Medi-Cal members each month in order to receive a Quality PMPM payment for that month.

Getting Help

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

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

2025 GQ P4P PROGRAM MEASURE LIST:									
Domain	**Measure Name**	**Population**	**Tier 1**	**Tier 1.5**	**Tier 2 [1]**	**Tier 2.5 [2]**	**Tier 3 [3]**	**Tier 4 [4]**	**Measure Weight**
Clinical Quality	Asthma Medication Ratio	Adult	**If baseline is below 25th percentile:** 10% reduction in non-compliance **AND** must meet the 25th percentile **If baseline is at or above 25th percentile: Improvement of at least 2% points**	**If baseline is below 33rd percentile:** 15% reduction in non-compliance **AND** must meet the 33rd percentile **If baseline is at or above 33rd percentile: Improvement of at least 2% points**	68%	73%	74%	79%	3.0
Clinical Quality	Colorectal Cancer Screening	Adult			40%	44%	46%	51%	1.0
Clinical Quality	Controlling High Blood Pressure	Adult			66%	69%	71%	75%	3.0
Clinical Quality	Diabetes Care- Blood Pressure Control <140/90	Adult			71%	74%	76%	79%	3.0
Clinical Quality	Glycemic Status Assessment for Patients with Diabetes	Adult			59%	62%	63%	66%	3.0
Clinical Quality	Diabetes Care- Kidney Health Evaluation	Adult			38%	44%	47%	52%	1.0
Clinical Quality	Adult Influenza Vaccine	Adult			18%	20%	22%	28%	1.0
Clinical Quality	Adult Pneumococcal Vaccine	Adult			46%	57%	60%	70%	1.0
Clinical Quality	Adult Td/Tdap Vaccine	Adult			40%	49%	52%	60%	1.0
Clinical Quality	Adult Zoster Vaccine	Adult			13%	15%	18%	23%	1.0
Clinical Quality	Adult Hepatitis B Vaccine[6]	Adult	Monitoring Only						NA
Clinical Quality	Post Discharge Follow-Up	Adult	**If baseline is below 25th percentile:** 10% reduction in non-compliance **AND** must meet the 25th percentile **If baseline is at or above 25th percentile: Improvement of at least 2% points**	**If baseline is below 33rd percentile:** 15% reduction in non-compliance **AND** must meet the 33rd percentile **If baseline is at or above 33rd percentile: Improvement of at least 2% points**	61%	71%	74%	89%	1.0
Clinical Quality	Statin Therapy Received for Patients with Cardiovascular Disease and Diabetes[5]	Adult			75%	77%	78%	81%	1.0
Clinical Quality	Breast Cancer Screening	Women			55%	59%	62%	65%	1.0
Clinical Quality	Cervical Cancer Screening	Women			59%	62%	64%	69%	1.0
Clinical Quality	Chlamydia Screening	Women			58%	63%	66%	71%	1.0
Clinical Quality	Child and Adolescent Well- Care Visits	Child			54%	57%	60%	67%	1.0
Clinical Quality	Childhood Immunizations - Combo 10	Child			29%	33%	37%	44%	3.0
Clinical Quality	Developmental Screening	Child			38%	45%	48%	55%	1.0
Clinical Quality	Immunizations for Adolescents- Combo 2	Child			36%	41%	44%	51%	3.0
Clinical Quality	Lead Screening for Children	Child			66%	71%	73%	82%	1.0

2025 GQ P4P PROGRAM MEASURE LIST:									
Domain	**Measure Name**	**Population**	**Tier 1**	**Tier 1.5**	**Tier 2 [1]**	**Tier 2.5 [2]**	**Tier 3 [3]**	**Tier 4 [4]**	**Measure Weight**
Clinical Quality	Well-Child Visits First 15 Months of Life	Child	**If baseline is below 25th percentile:** 10% reduction in non-compliance **AND** must meet the 25th percentile **If baseline is at or above 25th percentile: Improvement of at least 2% points**	**If baseline is below 33rd percentile:** 15% reduction in non-compliance **AND** must meet the 33rd percentile **If baseline is at or above 33rd percentile: Improvement of at least 2% points**	62%	65%	67%	72%	1.0
Clinical Quality	Well-Child Visits First 30 Months of Life	Child			71%	74%	75%	82%	1.0
Clinical Quality	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - BMI	Child			85%	88%	90%	93%	1.0
Clinical Quality	Initial Health Appointment	All			65%	76%	79%	87%	1.0
Access	Potentially Avoidable ED Visits	All	<5.0%	NA	NA	NA	NA	NA	1.0
Patient Experience	Access to Care Needed Right Away	All	86%*	NA	87%**	NA	90%***	NA	1.5
Patient Experience	Coordination of Care	All	87%*	NA	89%**	NA	93%***	NA	1.5
Patient Experience	Rating of Access to Routine Care	All	82%*	NA	84%**	NA	88%***	NA	1.5
Patient Experience	Rating of Personal Doctor	All	71%*	NA	73%**	NA	76%***	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 2 goals set at the 50th percentile as published in the 2024 (MY 2023) NCQA Quality Compass with a trend adjustment factor applied.*
[2] *Tier 2.5 goals set at the 66th percentile as published in the 2024 (MY 2023) NCQA Quality Compass with a trend adjustment factor applied.*
[3] *Tier 3 goals set at the 75th percentile as published in the 2024 (MY 2023) NCQA Quality Compass with a trend adjustment factor applied.*
[4] *Tier 4 goals set at the 90th percentile as published in the 2024 (MY 2023) NCQA Quality Compass with a trend adjustment factor applied.*
[5] *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 this combined measure will be calculated to produce one rate for this measure. The minimum denominator requirement for this measure is 10 eligible Members.*
[6] *Reporting Only Measure. Measure will be scorable for MY2026.*

2025 25TH & 33RD PERCENTILE RATES			
Domain	**Measure Name**	**25th Percentile Rate**	**33rd Percentile Rate**
Clinical Quality	Asthma Medication Ratio	61%	64%
Clinical Quality	Colorectal Cancer Screening	34%	36%
Clinical Quality	Controlling High Blood Pressure	62%	63%
Clinical Quality	Diabetes Care - Blood Pressure Control <140/90	65%	67%
Clinical Quality	Glycemic Status Assessment for Patients with Diabetes	54%	57%
Clinical Quality	Diabetes Care - Kidney Health Evaluation	33%	35%
Clinical Quality	Developmental Screening	28%	31%
Clinical Quality	Adult Influenza Vaccine	13%	15%
Clinical Quality	Adult Pneumococcal Vaccine	37%	41%
Clinical Quality	Adult Td/Tdap Vaccine	32%	35%
Clinical Quality	Adult Zoster Vaccine	7%	9%
Clinical Quality	Post Discharge Follow Up	43%	50%
Clinical Quality	Statin Therapy Received for Patients with Cardiovascular Disease and Diabetes	71%	73%
Clinical Quality	Breast Cancer Screening	50%	51%
Clinical Quality	Cervical Cancer Screening	52%	54%
Clinical Quality	Chlamydia Screening	52%	54%
Clinical Quality	Child and Adolescent Well-Care Visits	49%	50%
Clinical Quality	Childhood Immunizations - Combo 10	25%	26%
Clinical Quality	Immunizations for Adolescents - Combo 2	32%	33%
Clinical Quality	Lead Screening for Children	55%	60%
Clinical Quality	Well-Child Visits First 15 Months of Life	56%	59%
Clinical Quality	Well-Child Visits First 30 Months of Life	68%	69%
Clinical Quality	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents -BMI	77%	79%
Clinical Quality	Initial Health Appointment	52%	58%

The 25th and 33rd 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 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

Colorectal Cancer Screening (COL-E)

Summary of Changes to the 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	0464U	Oncology (colorectal) screening, quantitative real-time target and signal amplification, methylated DNA markers, including LASS4, LRRC4 and PPP2R5C, a reference marker ZDHHC1, and a protein marker (fecal hemoglobin), utilizing stool, algorithm reported as a positive or negative result
Colorectal Cancer Screening	CPT	44388	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
Colorectal Cancer Screening	CPT	44389	Colonoscopy Through Stoma; With Biopsy, Single Or Multiple
Colorectal Cancer Screening	CPT	44390	Colonoscopy Through Stoma; With Removal Of Foreign Body(s)
Colorectal Cancer Screening	CPT	44391	Colonoscopy Through Stoma; With Control Of Bleeding, Any Method
Colorectal Cancer Screening	CPT	44392	Colonoscopy Through Stoma; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Hot Biopsy Forcep
Colorectal Cancer Screening	CPT	44394	Colonoscopy Through Stoma; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Snare Technique
Colorectal Cancer Screening	CPT	44401	Colonoscopy Through Stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	44402	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	44403	Colonoscopy Through Stoma; With Endoscopic Mucosal Resection
Colorectal Cancer Screening	CPT	44404	Colonoscopy Through Stoma; With Directed Submucosal Injection(s), Any Substance
Colorectal Cancer Screening	CPT	44405	Colonoscopy through stoma; with transendoscopic balloon dilation
Colorectal Cancer Screening	CPT	44406	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
Colorectal Cancer Screening	CPT	44407	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
Colorectal Cancer Screening	CPT	44408	Colonoscopy through stoma; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
Colorectal Cancer Screening	CPT	45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
Colorectal Cancer Screening	CPT	45331	Sigmoidoscopy, Flexible; With Biopsy, Single Or Multiple
Colorectal Cancer Screening	CPT	45332	Sigmoidoscopy, Flexible; With Removal Of Foreign Body(s)
Colorectal Cancer Screening	CPT	45333	Sigmoidoscopy, Flexible; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Hot Biopsy Forceps

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

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
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
Colorectal Cancer Screening	CPT	45398	Colonoscopy, Flexible; With Band Ligation(s) (e.g., Hemorrhoids)
Colorectal Cancer Screening	CPT	74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material
Colorectal Cancer Screening	CPT	74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed
Colorectal Cancer Screening	CPT	74263	Computed Tomographic (ct) Colonography, Screening, Including Image Postprocessing
Colorectal Cancer Screening	CPT	81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
Colorectal Cancer Screening	CPT	82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection)
Colorectal Cancer Screening	CPT	82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
Colorectal Cancer Screening	HCPCS	G0104	Colorectal Cancer Screening; Flexible Sigmoidoscopy
Colorectal Cancer Screening	HCPCS	G0105	Colorectal Cancer Screening; Colonoscopy On Individual At High Risk
Colorectal Cancer Screening	HCPCS	G0121	Colorectal Cancer Screening; Colonoscopy On Individual Not Meeting Criteria For High Risk
Colorectal Cancer Screening	HCPCS	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, one to three simultaneous determinations

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

Controlling High Blood Pressure (CBP)

Methodology: HEDIS®

Measure Description: The percentage of Members who are 18-85 years of age, with a diagnosis of hypertension (HTN), and whose blood pressure (BP) was controlled (<140/90 mm Hg) during the measurement year (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 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 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 (e.g., basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (e.g., 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 (e.g., 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 (e.g., 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 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) visits, nonacute inpatient encounters 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 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 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 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)

CODES TO IDENTIFY ESTIMATED GLOMERULAR FILTRATION RATE:			
Service	**Code Type**	**Code**	**Code Description**
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)
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

CODES TO IDENTIFY URINE ALBUMIN-CREATININE RATIO LAB TEST:			
Service	**Code Type**	**Code**	**Code Description**
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
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

NOTE: IEHP will reimburse Providers for the serum used to administer adult immunizations for measurement year 2025 (dates of services January through December 2025). The provider office must have administered the immunization to be eligible for the reimbursement of the serum.
NOTE: Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHFs) and Rural Health Clinics (RHCs) are not eligible to receive the 2025 Adult Immunization Reimbursement payment. Please see Appendix 12 below for reimbursement payment amounts.

Adult Zoster Vaccine (AISZ)

Summary of Changes to the 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 20, 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

NOTE: IEHP will reimburse Providers for the serum used to administer adult immunizations for measurement year 2025 (dates of services January through December 2025). The provider office must have administered the immunization to be eligible for the reimbursement of the serum.
NOTE: Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHFs) and Rural Health Clinics (RHCs) are not eligible to receive the 2025 Adult Immunization Reimbursement payment. Please see Appendix 12 below for reimbursement payment amounts.

Adult Pneumococcal Vaccine (AISP)

Summary of Changes to the 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:
  - 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	90684	Pneumococcal conjugate vaccine, 21 valent (PCV21), 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

NOTE: IEHP will reimburse Providers for the serum used to administer adult immunizations for measurement year 2025 (dates of services January through December 2025). The provider office must have administered the immunization to be eligible for the reimbursement of the serum. NOTE: Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHFs) and Rural Health Clinics (RHCs) are not eligible to receive the 2025 Adult Immunization Reimbursement payment. Please see Appendix 12 below for reimbursement payment amounts.

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

NOTE: IEHP will reimburse Providers for the serum used to administer adult immunizations for measurement year 2025 (dates of services January through December 2025). The provider office must have administered the immunization to be eligible for the reimbursement of the serum. Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHFs) and Rural Health Clinics (RHCs) are not eligible to receive the 2025 Adult Immunization Reimbursement payment. Please see Appendix 12 below for reimbursement payment amounts.

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 by the end 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 (2025).

Denominator: Members 19 years 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 Tdap 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

NOTE: IEHP will reimburse Providers for the serum used to administer adult immunizations for measurement year 2025 (dates of services January through December 2025). The provider office must have administered the immunization to be eligible for the reimbursement of the serum. NOTE: Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHFs) and Rural Health Clinics (RHCs) are not eligible to receive the 2025 Adult Immunization Reimbursement payment. Please see Appendix 12 below for reimbursement payment amounts.

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.

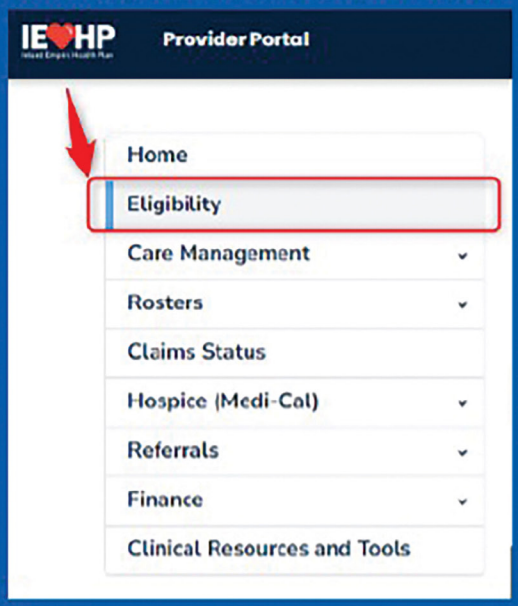
As part of IEHP's population health strategy, all IEHP Members are designated a risk level based on all available utilization and diagnostic data available to the plan. Members fall into one of three risk categories: High, Rising and Low Risk. IEHP leverages the John Hopkins ACG System to determine Member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

- 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:

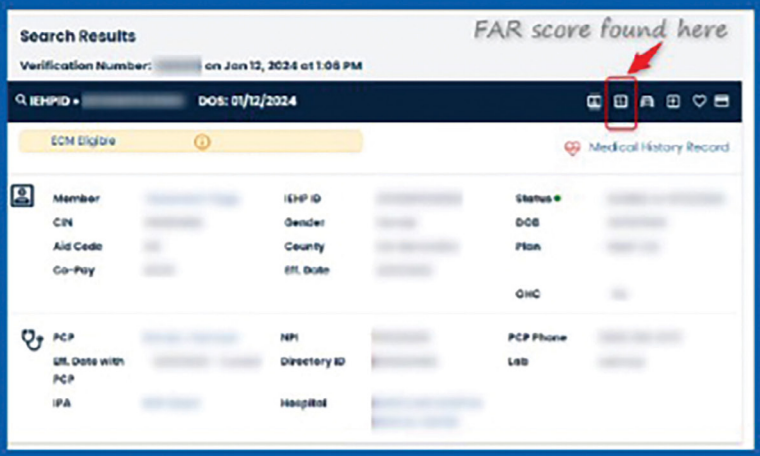
Step 1:

Locate IEHP member in eligibility on IEHP Secure Provider Portal



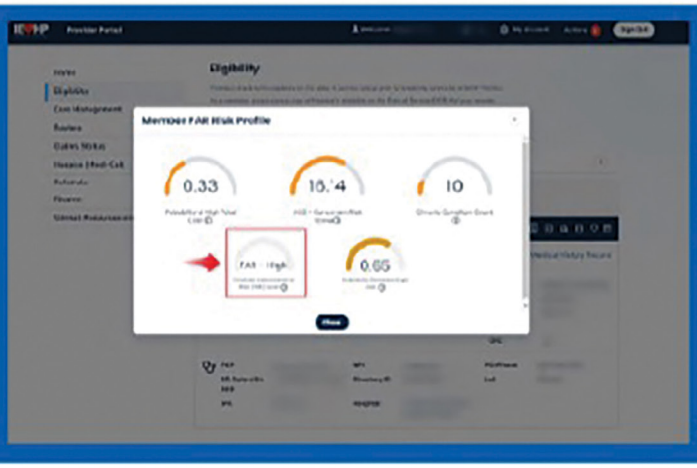
Step 2:

Click icon for "FAR score"



Step 3:

View "FAR score"



CODES TO IDENTIFY FOLLOW-UP 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 FOLLOW-UP 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	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 VISITS:			
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 2 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 2 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 VISITS:			
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)

CODES TO IDENTIFY ONLINE ASSESSMENTS:			
Service	**Code Type**	**Code**	**Code Description**
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
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 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 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 40-60 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 40-60 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: Women

MCAS Measure

Breast Cancer Screening (BCS-E)

Summary of Changes to the Global Quality P4P Program Guide:

- Update to measure title
- Update to measure description

Methodology: HEDIS®

Measure Description: The percentage of Members 40-74 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).

Rate 1: This measure assesses the percentage of Members ages 42-51 who were recommended for a routine breast cancer screening and had a mammogram to screen for breast cancer within the required timeframes.

NOTE: Rate 1 will be monitor only.

Rate 2: This measure assesses the percentage of Members ages 52-74 who were recommended for a routine breast cancer screening and had a mammogram to screen for breast cancer within the required timeframes.

- The eligible population in the measure meets all of the following criteria:
  1. Members 42-74 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)

CODES USED TO IDENTIFY MAMMOGRAPHY:			
Service	**Code Type**	**Code**	**Code Description**
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 42-74 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 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 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

CODES TO IDENTIFY HPV TESTS:			
Service	**Code Type**	**Code**	**Code Description**
Cervical Cancer Screening	CPT	0502U	Human papillomavirus (HPV), E6/E7 markers for high-risk types (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, and 68), cervical cells, branched-chain capture hybridization, reported as negative or positive for high risk for HPV
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.

Chlamydia Screening (CHL)

Summary of Changes to the 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, were recommended for routine chlamydia screening, and 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	Nonxynol 9

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

☑ Population: Child

MCAS Measure

Child and Adolescent Well-Care Visits (WCV)

Summary of Changes to the 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)
Well-Care Visit	CPT	99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years

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

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

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

Denominator: The eligible population.

- Anchor Date December 31, 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).

Childhood Immunizations (CIS-E) – Combo 10

Summary of Changes to the 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

CHILDHOOD IMMUNIZATION CODE SET:			
Antigen	**Code Type**	**Code**	**Code Description**
VZV	CPT	90710	Measles Mumps Rubella And Varicella Vaccine (MMRV) Live For Subcutaneous Use
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	90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 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	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 use
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.
    4. Members who had an Organ and Bone Marrow Transplant

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. The following are acceptable modifiers: SA, GN, GO, GP, GQ, GT, U9, 59, XE, XS, XP, XU and EP.

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

QUALITY BONUS SERVICE

MCAS Measure

Immunizations for Adolescents (IMA-E) – Combo 2

Summary of Changes to the 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
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

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

MCAS Measure

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

Summary of Changes to the 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 1 year)
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 1 through 4 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 1 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 1 through 4 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 is optional. If code is selected for this measure, code must be billed as the Primary diagnosis on encounter for the encounter to process correctly.*

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
BMI Percentile	ICD10	Z68.55	Body mass index [BMI] pediatric, 120% of the 95th percentile for age to less than 140% of the 95th percentile for age
BMI Percentile	ICD10	Z68.56	Body mass index [BMI] pediatric, greater than or equal to 140% 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.

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

CODES TO IDENTIFY IHA VISITS:		
Code Type	**Code**	**Description**
HCPCS	T1015	Clinic visit/encounter, all-inclusive.
ICD10CM	Z00.00	Encounter for general adult medical examination without abnormal findings.
ICD10CM	Z00.01	Encounter for general adult medical examination with abnormal findings.
ICD10CM	Z00.121	Encounter for routine child health examination with abnormal findings.
ICD10CM	Z00.129	Encounter for routine child health examination without abnormal findings.
ICD10CM	Z02.5	Encounter for examination for participation in sport.

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?

- 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 level.

Rating of Personal Doctor (MSS)

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

Measure Description: 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?

- Valid response: 0-10
- Target response: 9 or 10

Measure Support: Each year, 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 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 PCP on the date of service. This is the final count of preventable ED visits.

Rate: (Numerator / Denominator) x 12,000

PROCESS MEASURE

Process Measure

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

For the 2025 program year, Providers can earn an additional PMPM up to $0.75 PMPM for the process measure listed below, for meeting the process measure goal. Please see Appendix 3 below for details.

APPENDIX 3: *2025 PCP Global Quality Process Measure*

2025 GLOBAL QUALITY PCP PROCESS MEASURE LIST:		
Measure Name	**Goal**	**Incentive Amount (PMPM*)**
Manifest MedEx (MX) Connectivity	Five (5) Milestones are included in the Manifest MedEx (MX) Connectivity measure: – Milestone (1) Get Connected (Monitor Only) – Milestone (2) Stay Connected – Milestone (3) Improve Data Quality - Minimum Data Requirements – Milestone (4) Improve Data Quality - Clinical Data Elements – Milestone (5) Improve Data Quality - Behavioral Health Data Elements (Monitor Only)	Milestone (1) Monitor Only Milestone (2) $0.25 Milestone (3) $0.25 Milestone (4) $0.25 Milestone (5) Monitor Only

**PMPM: Per member Per Month*

APPENDIX 4: *Process Measure Overview*

Manifest MedEx (MX) Connectivity

Methodology: IEHP-Defined Process Measure

Measure Description: Providers are encouraged to continue utilizing the Manifest MedEx (MX) Connectivity platform to help improve data quality efforts.

Five (5) milestones are included in the Manifest MedEx (MX) Connectivity measure:

2025 PCP INCENTIVES FOR MX- MEASURE MILESTONES:			
Milestone*	**Milestone Category**	**Description**	**Payment**
1	Get Connected	Monitor PCPs connection with Manifest MedEx (MX).	Monitoring Only
2	Stay Connected	PCPs who successfully connected to MX: • Must continue to report data throughout the year. • Must participate in data validation activities, as directed.	$0.25
3	Improve Data Quality - Minimum Data Requirements	Ensure reporting of core data elements: • Patient ID, Provider NPI, Location NPI, Date of Service, Service/Procedure Codes	$0.25
4	Improve Data Quality - Clinical Data Elements	Ensure reporting of clinical data elements: • Blood Pressure Results - systolic / diastolic, member information, date of service	$0.25
5	Improve Data Quality - Behavioral Health (BH) Data Elements	Monitor ability to report BH data elements: • Depression Screening, results and follow up - PHQ-9 assessments and results, member, date of service - July 1 reporting to begin - monitoring only for 2025	Monitoring Only

** Providers eligible for milestone 1 cannot participate in milestones 2-5, cited above, for the 2025 performance year. Providers who established their MX connection in the 2022, 2023, or 2024 performance years are eligible for milestones 2-5. Provider must document all data elements in the Electronic Medical Record (EMR). Documents scanned into the chart will not count as compliant for this measure.*

Bonus Bundles

The bonus bundle measures allow Providers the opportunity to obtain additional P4P incentive earnings towards their monthly Quality PMPM. Providers can earn up to two (2) bonus bundles! All goals within the bundle must be met in order to earn. Providers can earn up to an additional $1.00 PMPM per bonus bundle for meeting all the bonus bundle goals.

APPENDIX 5: *2025 PCP Global Quality Bonus Bundles*

2025 GLOBAL QUALITY PCP BONUS BUNDLES :			
Bundle Name	**Includes**	**Goal**	**Value**
Adolescent	1) Well-Care Visits – Ages 12-17 2) Immunizations for Adolescents Combo 2 3) Chlamydia Screening – Ages 16-20	60% 44% 66%	$1.00 PMPM
Cancer Screening	1) Breast Cancer Screening 2) Cervical Cancer Screening 3) Colorectal Cancer Screening	62% 64% 46%	$1.00 PMPM
Cardiovascular	1) Controlling High Blood Pressure 2) Statin Therapy for Patients with Cardiovascular Disease – Received 3) Statin Therapy for Patients with Cardiovascular Disease – Adherence	71% 86% 78%	$1.00 PMPM
Diabetes*	1) Glycemic Status Assessment for Patients with Diabetes 2) Diabetes Care – Blood Pressure Control <140/90 3) Diabetes Care – Kidney Health Evaluation 4) Statin Therapy for Patients with Diabetes – Received	63% 76% 47% 70%	$1.00 PMPM
Early Childhood*	1) Childhood Immunizations Combo 10 2) Well-Child Visits First 15 Months of Life 3) Well-Child Visits First 15-30 Months of Life 4) Developmental Screening in the First 3 years of Life	37% 67% 75% 48%	$1.00 PMPM
Patient Experience*	1) Rating of Access to Routine Care 2) Coordination of Care 3) Rating of Personal Doctor 4) Customer Service Grievance	88% 93% 76% ≤ 3.0 PTMPY	$1.00 PMPM

Global Quality PCP Bonus Bundle Goals set at the 75th percentile as published in the 2024 (MY 2023) NCQA Quality Compass, Patient Experience goals set at the 90th percentile as published in the 2024 (MY 2023) NCQA Quality Compass.

**If a bundle has 4 measures and the Provider has a scoreable denominator for 3 out of the 4 measures, then the Provider is eligible for the Bonus Bundle incentive. This would impact the following bundles: Diabetes, Early Childhood and Patient Experience.*

QUALITY BONUS SERVICES

☑ Global Quality P4P Quality Bonus Services (for PCPs)

The 2025 Global Quality P4P (GQ P4P) Program includes the Quality Bonus Services. The services included in this domain are linked to key quality measures that are low performing and were previously covered under the DHCS Value-Based Payments Program. Appendix 6 references the payment amounts per Quality Bonus Service, and Appendix 7 provides service details, including service requirements for payment.

☑ Eligibility and Participation

To be eligible for the Quality Bonus Services, Providers must be contracted with IEHP as a Medi-Cal Primary Care Physician (PCP) participating in the 2025 Global Quality P4P Program.

NOTE: Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHFs) and Rural Health Clinics (RHCs) are **only** eligible for the following Quality Bonus Services:

- 3 Monthly Supply Asthma Prescription Conversion
- Symbicort Initiation for Persistent Asthma

☑ Financial Overview

All quality bonus services must be captured through normal reporting channels with the Providers assigned IPA. The quality bonus services will be paid following the Quality Bonus Payment Schedule.

2025 GLOBAL QUALITY P4P – QUALITY BONUS SERVICES PAYMENT SCHEDULE		
Date of Service:	**Encounter Received:**	**Payment Date:**
1/1/2025 – 1/31/2025	2/15/2025	3/20/2025
1/1/2025 – 2/28/2025	3/15/2025	4/20/2025
1/1/2025 – 3/31/2025	4/15/2025	5/20/2025
1/1/2025 – 4/30/2025	5/15/2025	6/20/2025
1/1/2025 – 5/31/2025	6/15/2025	7/20/2025
1/1/2025 – 6/30/2025	7/15/2025	8/20/2025
1/1/2025 – 7/31/2025	8/15/2025	9/20/2025
1/1/2025 – 8/31/2025	9/15/2025	10/20/2025
1/1/2025 – 9/30/2025	10/15/2025	11/20/2025
1/1/2025 – 10/31/2025	11/15/2025	12/20/2025
1/1/2025 – 11/30/2025	12/15/2025	1/20/2026
1/1/2025 – 12/31/2025	1/15/2026	2/20/2026
1/1/2025 – 12/31/2025	2/15/2026	3/20/2026
1/1/2025 - 12/31/2025	3/15/2026	4/20/2026*

NOTE: The 3 Month Supply Asthma Prescription Conversion and Symbicort Initiation for Persistent Asthma services will not be included in the Quality Bonus Services monthly payment schedule.

**IEHP will issue a lump sum payment for the 3 Month Supply Asthma Prescription Conversion and Symbicort Initiation for Persistent Asthma services, to qualified Providers, April 2026.*

APPENDIX 6: *2025 PCP Global Quality P4P Quality Bonus Services*

QUALITY BONUS SERVICE – PAYMENT PER SERVICE:	
Service	**Amount**
Pediatric Immunizations Administration	$18.00
Lead Screening	$25.00
Dental Fluoride Varnish	$25.00 or $50.00*
3 Month Supply Asthma Prescription Conversion	$25.00
Symbicort Initiation for Persistent Asthma	$25.00

**Please see Dental Fluoride Varnish service description for payment details.*

APPENDIX 7: *Quality Bonus Services Overview*

Pediatric Immunizations Administration ($18)

Service Description: Quality bonus payment to a Provider for each pediatric immunization administered for Members 0-18 years of age for antigens included in the Childhood Immunization Combo 10 (CIS-E) or Immunizations for Adolescents (IMA-E) measure.

- Payment based on antigen administered
- Payment to each rendering Provider who administered the pediatric immunization
- Effective for dates of service 1/1/2025-12/31/2025
- Payment eligible for all antigens included in the CIS-E or IMA-E measures
- One payment per Member per antigen per date of service allowed
- Members must be between ages 0-18 at the time of the shot administration
- Provider must bill the antigen code for the antigen being administered

PEDIATRIC IMMUNIZATION CODE SET:			
Service	**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

PEDIATRIC IMMUNIZATION CODE SET:			
Service	**Code Type**	**Code**	**Code Description**
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
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

PEDIATRIC IMMUNIZATION CODE SET:			
Service	**Code Type**	**Code**	**Code Description**
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
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	90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 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	90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use

PEDIATRIC IMMUNIZATION CODE SET:			
Service	**Code Type**	**Code**	**Code Description**
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 use
Flu	CPT	90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use
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
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
Tdap	CPT	90715	Tetanus Diphtheria Toxoids And Acellular Pertussis Vaccine (Tdap) When Administered To Individuals 7 Years Or Older For Intramuscular Use
HPV	CPT	90649	Human Papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use
HPV	CPT	90650	Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 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

Blood Lead Screening ($25)

Service Description: Quality bonus payment to a Provider for completing a blood lead service screening in their office for children up to 2 years of age.

- Payment to each rendering Provider for each blood lead screening on or before the Member's second birthday
- Effective dates of service 1/1/2025-12/31/2025
- One payment per Member per date of service allowed
- Blood lead tests will not be excluded if a child is diagnosed with lead toxicity
- Provider must bill blood lead screening code

BLOOD LEAD SCREENING CODE:			
Service	**Code Type**	**Code**	**Code Description**
Blood Lead Screening	CPT	83655	Lead

Dental Fluoride Varnish ($25-$50*)

Service Description: Quality bonus payment to a Provider when oral fluoride varnish application is rendered to members 1 year through 20 years of age (1 year - 20.99 years of age).

- Payment to each rendering Provider for each occurrence of dental fluoride application
- Up to two payments per Member per Provider per year
- One payment per Member per date of service allowed
- Provider must bill one fluoride varnish code
- *Effective for dates of service 1/1/2025 - 12/31/2025:
  - $25 for the first application
  - $50 for the second application

DENTAL FLUORIDE VARNISH CODES:			
Service	**Code Type**	**Code**	**Code Description**
Fluoride Varnish	CPT	99188	Application of topical fluoride varnish by a physician or other qualified health care professional
Fluoride Varnish	CDT	D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients
Fluoride Varnish	CDT	D1208	Topical Application of fluoride – excluding varnish

3 Month Supply Asthma Prescription Conversion ($25*)

Service Description: Quality bonus payment to a Provider who successfully converts eligible controller inhalers to 3 month supply, for members diagnosed with persistent asthma.

- Effective dates of prescription filled: 7/1/25 – 12/31/2025
- Maximum incentive is one per Provider, per Member qualified dispensed medication.
- *Payment for this service will be distributed April 2026
- Providers must work from the IEHP member roster for this service.

TABLE 1. FILL CONVERSION – QUALIFYING MEDICATION LIST	
Description	**Prescription**
Antibody inhibitors	Omalizumab
Anti-interleukin-4	Dupilumab
Anti-interleukin-5	Benralizumab
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

NOTE: FQHC, RHC and IHF Provider Clinics are eligible for the 3 Monthly Supply Asthma Prescription Conversion Quality Bonus Service. IEHP will pay qualified FQHC, RHC and IHF Providers, $25 incentive per eligible prescription, for Provider Clinics that reach the 80% compliance target for the incentive service, by December 31, 2025.

Symbicort Initiation for Persistent Asthma ($25*)

Service Description: Quality bonus payment to a Provider who prescribes Symbicort to members, ages 12 - 64, not currently filling a controller inhaler, who have been diagnosed with persistent asthma and prescription dispensed.

- Effective dates of prescription filled: 7/1/25 – 12/31/2025
- Maximum incentive is one per Provider, per Member qualified dispensed medication.
- *Payment for this service will be distributed April 2026
- Providers must work from the IEHP member roster for this service.

CLINICAL NOTE: Symbicort initiation for each member needs to be evaluated to ensure it is clinically appropriate per 2024 Global Initiatives for Asthma (GINA) guidelines, package insert, and patient-specific considerations. Please use your clinical judgement to assess whether each member is appropriate.

NOTE: FQHC, RHC and IHF Provider Clinics are eligible for the Symbicort Initiation for Persistent Asthma Quality Bonus Service. IEHP will pay qualified FQHC, RHC and IHF Providers, $25 incentive per eligible prescription, for Provider Clinics that reach the 80% compliance target for the incentive service, by December 31, 2025.

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 $1.50 PMPM. Please see Appendix 8 for penalty details.

APPENDIX 8: *2025 PCP Global Quality P4P Quality Penalty Measures*

2025 GQ P4P PCP 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%	$1.00

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

APPENDIX 9: *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 encounters (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.

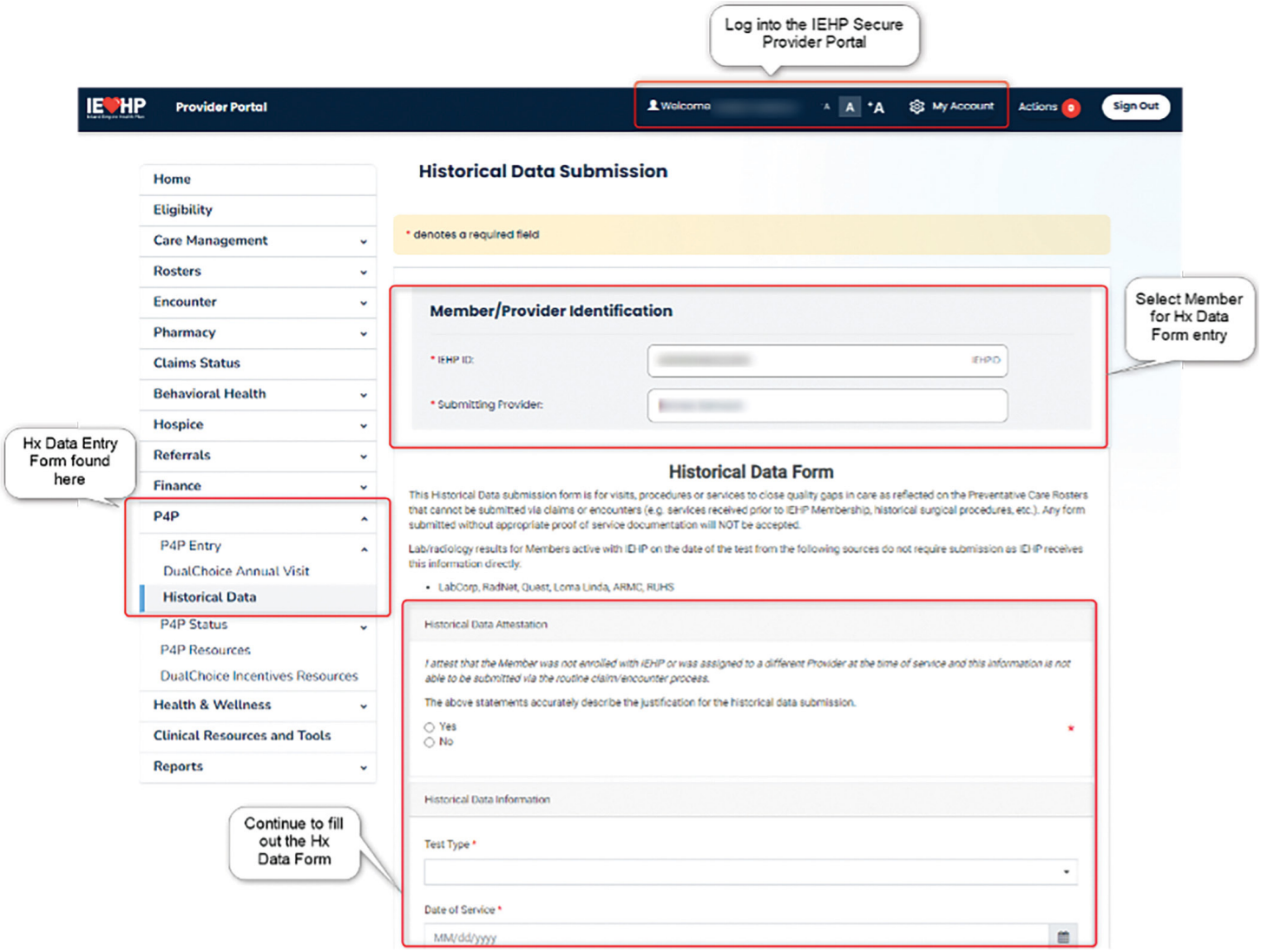
Measure Support: The purpose of the Medi-Cal Managed Care Accountability Set (MCAS) Performance measure is to ensure IEHPs performance is aligned with Medi-Cal Managed Care Accountability Set (MCAS) performance goals established by the Department of Health Care Services (DHCS). MCAS is a set of performance 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	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 10: *Historical Data Form*

The IEHP Historical (Hx) Data Form is located in the secure Provider Portal. Providers seeking to submit medical records to close quality gaps in care can enter Member information and upload documentation via an online process. As a reminder, this process 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.). Please see below for more details.



NOTE: All Historical Data submissions for the 2025 performance year must be submitted to IEHP no later than December 31, 2025.

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,

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 12: *2025 Adult Immunization Reimbursement Amounts*

IEHP will reimburse Providers for the serum used to administer adult immunizations for measurement year 2025 (dates of services January through December 2025). The provider office must have administered the immunization to be eligible for the reimbursement of the serum. NOTE: Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHFs) and Rural Health Clinics (RHCs) are not eligible to receive the 2025 Adult Immunization Reimbursement payment. Please see Appendix 12 below for reimbursement payment amounts.

ADULT IMMUNIZATION REIMBURSEMENT AMOUNTS:				
Antigen	**Code Type**	**Code**	**Code Description**	**P4P Reimbursement**
Adult Influenza Vaccine	CPT	90630	Influenza Virus Vaccine, Quadrivalent (Iiv4), Split Virus, Preservative Free, For Intradermal Use	$30
Adult Influenza Vaccine	CPT	90653	Influenza Vaccine, Inactivated (Iiv), Subunit, Adjuvanted, For Intramuscular Use	$93
Adult Influenza Vaccine	CPT	90654	Influenza Virus Vaccine, Trivalent (Iiv3), Split Virus, Preservative Free, For Intradermal Use	$25
Adult Influenza Vaccine	CPT	90656	Influenza Virus Vaccine, Trivalent (Iiv3), Split Virus, Preservative Free, 0.5 Ml Dosage, For Intramuscular Use	$32
Adult Influenza Vaccine	CPT	90658	Influenza Virus Vaccine, Trivalent (Iiv3), Split Virus, 0.5 Ml Dosage, For Intramuscular Use	$31
Adult Influenza Vaccine	CPT	90660	Influenza Virus Vaccine, Trivalent, Live (Laiv3), For Intranasal Use	$38
Adult Influenza Vaccine	CPT	90662	Influenza Virus Vaccine (Iiv), Split Virus, Preservative Free, Enhanced Immunogenicity Via Increased Antigen Content, For Intramuscular Use	$93
Adult Influenza Vaccine	CPT	90672	Influenza Virus Vaccine, Quadrivalent, Live (Laiv4), For Intranasal Use	$37
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	$93
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	$44
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	$83
Adult Influenza Vaccine	CPT	90686	Influenza Virus Vaccine, Quadrivalent (Iiv4), Split Virus, Preservative Free, 0.5 Ml Dosage, For Intramuscular Use	$32
Adult Influenza Vaccine	CPT	90688	Influenza Virus Vaccine, Quadrivalent (Iiv4), Split Virus, 0.5 Ml Dosage, For Intramuscular Use	$30

ADULT IMMUNIZATION REIMBURSEMENT AMOUNTS:				
Antigen	**Code Type**	**Code**	**Code Description**	**P4P Reimbursement**
Adult Influenza Vaccine	CPT	90694	Influenza Virus Vaccine, Quadrivalent (aIIV4), Inactivated, Adjuvanted, Preservative Free, 0.5 Ml Dosage, For Intramuscular Use	$87
Adult Influenza Vaccine	CPT	90756	Influenza Virus Vaccine, Quadrivalent (Cciiv4), Derived From Cell Cultures,Subunit, Antibiotic Free, 0.5Ml Dosage, For Intramuscular Use	$42
Adult Zoster Vaccine	CPT	90750	Zoster (shingles) vaccine (HZV), recombinant, subunit, adjuvanted, for intramuscular use	$225
Adult Pneumococcal Vaccine	CPT	90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use; Includes Prevnar 13	$267
Adult Pneumococcal Vaccine	CPT	90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use; Includes Vaxneuvance	$263
Adult Pneumococcal Vaccine	CPT	90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use	$308
Adult Pneumococcal Vaccine	CPT	90684	Pneumococcal conjugate vaccine, 21 valent (PCV21), for intramuscular use	$337
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	$143
Adult Hepatitis B Vaccine	CPT	90739	Hepatitis B vaccine (HepB), CpG-adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use	$178
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	$83
Adult Hepatitis B Vaccine	CPT	90743	Hepatitis B vaccine (HepB), adolescent, 2 dose schedule, for intramuscular use	$85
Adult Hepatitis B Vaccine	CPT	90744	Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use	$40
Adult Hepatitis B Vaccine	CPT	90740	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use; Includes: Recombivax HB	$168
Adult Hepatitis B Vaccine	CPT	90746	Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use	$80
Adult Hepatitis B Vaccine	CPT	90747	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use	$150

ADULT IMMUNIZATION REIMBURSEMENT AMOUNTS:				
Antigen	**Code Type**	**Code**	**Code Description**	**P4P Reimbursement**
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	$43
Adult Tdap 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	$48

NOTE: The Adult Immunization Reimbursement payments will be distributed on the 20th monthly.

ADULT IMMUNIZATION REIMBURSEMENT DETAILS: The below table represents the frequency of the adult immunization reimbursements.	
Antigen	**Reimbursement Frequency**
Adult Influenza Vaccine	Two (2) reimbursements per Member, per year.
Adult Zoster Vaccine	Two (2) reimbursements per Member per their lifetime.
Adult Pneumococcal Vaccine	Two (2) reimbursements per Member, per their lifetime.
Adult Hepatitis B Vaccine	Reimbursement frequency will follow the below: • CPT Codes: 90739, 90743 - Two (2) reimbursements per Member per lifetime. • CPT Codes: 90759, 90744, 90746, 90740 - Three (3) reimbursements per Member per lifetime. • CPT Code: 90747 - Four (4) reimbursements per Member per lifetime.
Adult Td/Tdap Vaccine	One (1) reimbursement per Member per 10-year lookback (Td/Tdap vaccine given to member between calendar years 2016-2025)

APPENDIX 13: *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, 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	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	Provider	Recommended Immunization Schedule	CDC Adult Immunization Schedule.
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 Child Preventive Health	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	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 second hand smoke.
Asthma Management	Member	Staying Healthy With Asthma Booklet	Workbook to help Members learn how to manage their asthma.
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.
Asthma Management	Provider	Asthma Care Quick Reference	Guidelines from the National Asthma Education and Prevention Program.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
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	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.
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.
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.
Behavioral Health	Member	988 Suicide and Crisis Lifeline	National Suicide and Crisis Hotline/Textline in English and Spanish. Includes LGBTQI-specific help.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
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	Depression Resources	Links to clinical guidelines for screening and managing depression.
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.
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.
Child Preventive Health	Member	Teen Health Guide	Booklet provides age-appropriate information on reproduction, birth control methods, and sexually transmitted infections.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
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	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	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	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	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	Bright Futures/AAP Periodicity Schedule	Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.
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).

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
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	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.
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.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
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.
Pediatric Immunizations and Child Preventive Health	Member	Well Child Journey	Member handout detailing a child's wellness journey from newborn to young adulthood, including when immunizations and screenings are due.
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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Monday-Friday, 8am-5pm

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