Benchmark Pay for Performance

CareAdvantage Program Guidelines

2023 Program Year - Final Release

Click on blue underlines throughout to jump to relevant section

Summary of Changes from First Release:

1. Full and partial credit benchmarks established for CareAdvantage quality metric set.

MY2023 V2 - Updated July 1, 2023

Summary of Changes to 2023 **CareAdvantage** Program

Important changes to program:

1. MY2023 data submission deadlines changed to **02/28/2024** for claims and **03/09/2024** for supplemental data files.
2. **Improvement targets for partial credit** added to program. Beginning MY2023, clinics can receive partial credit for any quality metric in which they improve performance by a minimum 10% "improvement on the negative" compared to prior year. For more information, see section on Program Benchmarks and below for examples:
   - Ex 1: If MY2022 rate = 10%, then MY2023 partial credit awarded at ≥ 19% (10% improvement on 90% noncompliance)
   - Ex 2: If MY2022 rate = 90%, then MY2023 partial credit awarded at ≥ 91% (10% improvement on 10% noncompliance)
3. Z-Coding for Social Determinants of Health (**SDoH**) reporting-only quality metric added. Clinics are encouraged to identify a social determinant of health (e.g. housing insecurity, food insecurity) of interest and priority to screen for presence among HPSM members and report using eligible z-codes. See SDoH for more information.

Changes to quality metrics eligible for payment:

CareAdvantage Quality Metrics

- Eye Exam for Patients with Diabetes (**EED**) added as a payment metric.
- Care for Older Adults – Functional Status Assessment (**COA-FSA**) removed as a payment metric – now reporting-only.

Table of Contents

I . Program Overview

Health Plan of San Mateo's Benchmark Pay for Performance ("Benchmark P4P") program offers performance bonus payments to in-network Medi-Cal providers for targeted quality metrics to improve population health outcomes for HPSM members. The program is also designed to share data with HPSM providers on care information for their assigned HPSM patients. The targeted quality performance metric set focuses on member access and preventive care services.

Questions about the Benchmark P4P program may be directed to HPSM Provider Services at PSInquiries@hpsm.org.

Provider Eligibility

Primary care providers participate at the clinic-level. All primary care clinics are automatically opted-in to P4P bonus payment eligibility if they meet all of the following criteria:

1. Clinics must have a CareAdvantage primary care contract with HPSM active as of the measurement period start date through at least six months following the close of the measurement period;
2. Providers must have 50 HPSM Medi-Cal members assigned to their panel as of January 1st, 2023. If clinic assignment falls below 50 Medi-Cal members at any point during the measurement period, clinic may be asked to accept additional member assignment until the 50 minimum is achieved again in order to qualify for payment.

Quality Metric Selection

Quality metrics are selected for inclusion in the P4P program based on a number of factors, including:

- Baseline network performance
- Population health needs of HPSM members
- Regulatory requirements
- Strength of association between clinical process improvements and improved population health outcomes
- Provider input

Program Benchmarks

Standard Benchmarks

Benchmarks are derived from a combination of several factors, including:

- National performance benchmarks for HEDIS metrics;
- Prior year network performance;
- Critical mass thresholds for population health.

Benchmarks may be retro-adjusted downward in the event no clinic meets the full credit benchmark. Decisions to amend benchmarks are made during the payment calculation process after the close of data submission.

Improvement Targets

Beginning MY2023, clinics can receive partial credit for any quality metric in which their performance improves by an established margin compared to MY2022. A minimum 10% improvement "on the negative" is required to earn partial credit if partial credit benchmark is not otherwise reached.

- Ex 1: If MY2022 rate = 10%, then MY2023 partial credit awarded at ≥ 19 % (10% improvement on 90% non-compliance)
- Ex 2: If MY2022 rate = 90%, then MY2023 partial credit awarded at ≥ 91 % (10% improvement on 10% non-compliance)

Data Reports and Additional Coding Resources

Performance bonus payment in the Benchmark P4P program is contingent on meeting the specified metric benchmarks for assigned patients who meet the metric criteria. Once the encounter information has been received and eligibility has been determined, providers will get credit towards the annual benchmark. Monthly member detail benchmark progress reports are available to providers through the HPSM eReports portal. Reports for the MY 2023 Program Year will be published **at the beginning of each month between May 2023 and April 2024.** The website for eReports login is: https://reports.hpsm.org. Additional resources, including an eReports User Guide, coding guidelines, and code lists are available at: https://www.hpsm.org/provider/value-based-payment.

Program Timeline

The deadline for Benchmark P4P claims submission is March 31st following the program calendar year. This is to allow for a three month claims lag so that we capture as many encounters as possible to count towards meeting the quality benchmarks. Each participating provider will be eligible for performance bonuses calculated based on meeting benchmarks for assigned quality metrics in the program calendar year. In addition, participating providers are eligible to receive the monthly engagement benchmark bonus payments through capitation.

Period	**Dates** (subject to change)	**Description**
Program Year	01/01/2023 – 12/31/2023	This is the anchor program year for all dates of service (DOS). For metrics with a lookback period of multiple years, count 2023 as year 1.
Supplemental Data Submission Deadline	03/08/2024	All supplemental data (EMR extracts, lab submissions) must be submitted by this date to ensure timely processing for bonus payments.
Claims Submission Deadline	02/28/2024	All HPSM claims and qualifying codes must be submitted by this date to ensure timely processing for bonus payments.
Attestation Period	04/02/2024 – 04/30/2024	Providers may manually attest for compliance in cases where the claims submission process has not captured all relevant data. Instructions for attestation will be distributed Spring 2024.
Payment Finalization	05/01/2024 – 06/30/2024	HPSM compiles all performance data and calculates bonus payment using the formula below. Bonus is distributed via lump sum as a single check mailed to the financial address on file.

Incentive Payment Formula

Final Benchmark P4P total payments will be calculated using the following equation:

(Eligible Member Months * Composite Quality Score * $Benchmark P4P PMPM) + Full Credit Benchmark Bonus

Formula Term Definitions

Eligible Member Months: Total of all member months for CareAdvantage members assigned to the clinic/system for at least 9 months out of 12 during the calendar year. 9 months of assignment do NOT need to be continuous. 1 member month = 1 member assigned for every 1 month (i.e. 12 member months = 1 member assigned for 12 months or 12 members assigned for 1 month each). Members receiving hospice or palliative care services are excluded from all P4P rates, including eligible member months.

Composite Quality Score: Average score for all earned quality points based on final performance rate following the program calendar year. **For MY2023, earning full credit nets two (2) quality score points while partial credit nets one (1) point for all metrics.** For quality points to be attributed to an assigned metric, the participating provider must have at least one eligible patient in the denominator. If eligible patients is zero, provider is considered ineligible for that assigned metric and it is excluded from their composite quality score calculation.

$Benchmark P4P PMPM: Specific per member per month rate determined by HPSM. Allocations will be determined based on the pool of funds allocated for Benchmark P4P program and number of members covered by the program.

Full Credit Benchmark Bonus: Potential additional bonus amount added if clinic meets ALL full credit benchmarks for its assigned track's quality metric set in the program year.

II . CareAdvantage Quality Metric Summary

CareAdvantage Payment Quality Metric Set

Provider performance in the payment metrics below relative to the full and partial credit benchmarks earn quality score points used to generate a Composite Quality Score for incentive payments. For all MY2023 payment metrics, earning full credit nets two (2) quality score points and partial credit nets one (1) point.

Shorthand	Payment Metric Name	Metric Source	Performance Benchmarks	
			Full Credit	Partial Credit[i]
BCS	Mammogram for Breast Cancer Screening	HEDIS	76 %	69 %
CBP	Controlling High Blood Pressure	HEDIS	67 %	54 %
CDF	Depression Screening & Follow Up (12 years and older)	DHCS	68 %	52 %
COA-MR	Care for Older Adults – Medications Review	HEDIS	64 %	54 %
COA-PS	Care for Older Adults – Pain Screening	HEDIS	59 %	49 %
COL	Colorectal Screening	HEDIS	80 %	71 %
EED	Eye Exam for Patients with Diabetes	HEDIS	79 %	71 %
FLU	Seasonal Influenza Vaccine	HPSM	80 %	75 %
HBD-2*	Hemoglobin A1c Control (>9.0%) for Patients with Diabetes	HEDIS	15 %	27 %
TRC-MR	Transitions of Care – Medications Reconciliation Post-Discharge	HEDIS	53 %	42 %

**HBD-2 is an inverted metric (a lower rate is better)*

[i] Partial credit will also be awarded for 10% improvement "on the negative" compared to prior year. See Improvement Targets.

CareAdvantage Reporting-Only Quality Metric Set

HPSM collects performance data on the metrics below. Reporting-only metrics are not eligible for inclusion in payment calculations but are subject for inclusion as payment metrics in future P4P Program years. While provider performance is not measured against payment benchmarks, HPSM shares back prior year network performance data to continuously improve performance.

Shorthand	Reporting-Only Metric Name	Metric Source
ACP	Advance Care Planning	HEDIS
AMB-ED	Ambulatory ED Visits	HEDIS
Avoid-ED	Avoidable ED Visits	HPSM
COA-Complete	Care for Older Adults – Complete	HEDIS
COA-FSA	Care for Older Adults – Functional Status Assessment	HEDIS
DAE	Use of High-Risk Medications in the Elderly – One Prescription	HEDIS
HPC	Hospitalization for Potentially Preventable Complications	HEDIS
PCR	Plan All-Cause Readmissions	HEDIS
SBIRT	Substance Misuse Screening & Follow Up	HPSM
SDoH	Z-Coding for Social Determinants of Health	HPSM
TRC-PE	Transitions of Care – Patient Engagement Post-Discharge	HEDIS

III . Quality Metric Specifications

ACP: Advance Care Planning

CareAdvantage
Reporting-Only

Metric Source: HEDIS metric of the same name. Replaces former Care for Older Adults (COA) rate 1.

Patient Eligibility: All members excluding those in hospice care.

Metric Definition: The percentage of adults 66–80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older who had advance care planning during the measurement year.

AMB-ED: Ambulatory Care Emergency Visits

CareAdvantage
Reporting-Only

Metric Source: HPSM internal metric.

Patient Eligibility: All members excluding those in hospice and palliative care.

Exclusions:

- ED visits that result in an inpatient stay.
- Visits for mental health or chemical dependency.

Full and partial credit benchmarks will not be applied for this metric. HPSM's network rates will be reported back to providers.

Metric Definition: This metric summarizes utilization of ambulatory care for emergency department visits. Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.

Avoid-ED: Avoidable Emergency Department Visits

CareAdvantage
Reporting-Only

Metric Source: HPSM internal metric.

Patient Eligibility: Members 1 year and older who visited an emergency room.

Exclusions: Exclude members receiving hospice or palliative care during the measurement year.

Metric Definition: The percentage of avoidable ER visits among members 1 year of age and older. Avoidable visits are defined using the diagnosis codes referenced below.

Refer to **https://www.hpsm.org/provider/value-based-payment** for the complete list of qualifying ED diagnosis codes.

BCS: Mammogram for Breast Cancer Screening

CareAdvantage
Payment

Metric Source: HEDIS metric BCS.

Patient Eligibility: Women age 50-74 years old who have not had a bilateral mastectomy.

Exclusions:

- Members 66 years of age and older by the end of the Measurement Period, with frailty AND advanced illness
- Members receiving palliative care

Metric Definition: The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

Mammography Exclusion Code

Code	Definition	Code System
3014F with Modifier 1P	Screening mammography not performed for medical reasons	CPT II

Mammography Procedure Codes

Code	Definition	Code System
G0202	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (cad) when performed (G0202)	HCPCS
G0204	Diagnostic mammography, including computer-aided detection (cad) when performed; bilateral (G0204)	HCPCS
G0206	Diagnostic mammography, including computer-aided detection (cad) when performed; unilateral (G0206)	HCPCS
3014F	Screening mammography results documented and reviewed	CPT II
77055	Mammography	CPT
77056	Mammography	CPT
77057	Mammography	CPT
77061	Mammography	CPT
77062	Mammography	CPT
77063	Mammography	CPT
77065	Mammography	CPT
77066	Mammography	CPT
77067	Mammography	CPT

CBP: Controlling High Blood Pressure

CareAdvantage
Payment

Metric Source: HEDIS metric of the same name.

Patient Eligibility: Members 18-85 years old who had at least two visits and a diagnosis of hypertension in the year prior to the measurement year AND the first six months of the current measurement year.

Exclusion criteria:

- Medicare members 66 years old + who are enrolled in an I-SNP any time during the measurement year or living long-term in an institution at any time during the measurement year;
- Members 66-80 years old with both frailty AND advanced illness
- Members 81 years of age and older as of December 31 of the measurement year with frailty
- Members with evidence of end-stage renal disease (ESRD), dialysis, nephrectomy, or kidney transplant on or prior to December 31 of the measurement year
- Members with a diagnosis of pregnancy during the measurement year
- Members who had a nonacute inpatient admission during the measurement year
- Members receiving palliative care

Metric Definition: The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year. The representative BP reading is the most recent BP reading during the measurement year on or after the second diagnosis of hypertension.

Hypertension Diagnosis Code

Code	Definition	Code System
I10	Essential (primary) hypertension	ICD10CM

Codes for Blood Pressure Reading

Code	Definition	Code System
3074F	Most recent systolic blood pressure less than 130 mm Hg	CPT-II
3075F	Most recent systolic blood pressure 130-139 mm Hg	CPT-II
3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg	CPT-II
3078F	Most recent diastolic blood pressure less than 80 mm Hg	CPT-II
3079F	Most recent diastolic blood pressure 80-89 mm Hg	CPT-II
3080F	Most recent diastolic blood pressure greater than or equal to 90 mm Hg	CPT-II

CDF: Depression Screening and Follow-up (12 years and older)

CareAdvantage
Payment

Metric Source: HPSM internal metric.

Patient Eligibility: Patients 12 years old and up (patients who will turn 13 years of age as of December 31st of the measurement year) who had an outpatient visit during the measurement period.

Exclusions: Exclude patients who have a documented active diagnosis of depression or bipolar disorder.

Metric Definition: The percentage of patients 12 year of age and older who had an annual depression screening on the date of the encounter using a standard depression screening tool (including the HPSM Behavioral Health Screening tool available at: hpsm.org/provider-forms, which includes PHQ-2 standard screening questions)

- Screening must be documented in patient's medical record
- If screening is positive, follow-up plan must be documented on the date of the positive screen

For a complete list of outpatient visit codes, please refer to **https://www.hpsm.org/provider/value-based-payment**. Note that for the Depression Screening metric, additional outpatient visit codes may apply in order to adequately capture maternal health and other visit types.

Depression Screening Procedure Codes

Code	Definition	Code System
G8431	Screening for depression is documented as being positive and a follow-up plan is documented	HCPCS
G8433	Screening for clinical depression using a standardized tool not documented; patient not eligible/appropriate	HCPCS
G0444	Annual depression screening administration	HCPCS
G8510	Screening for depression is documented as negative, a follow-up plan is not required	HCPCS
G8511	Screening for depression documented as positive; follow-up plan is not documented and reason not given	CPT II
0545F	Plan for follow-up care for major depressive disorder documented (MDD ADOL)	CPT II
1220F	Patient screened for depression (SUD)	CPT II
3351F	Negative screen for depressive symptoms as categorized by using a standardizes depression assessment tool (MDD)	CPT II

3352F	No significant depressive symptoms as categorized by using a standardized depression assessment tool (MDD)	CPT II
3353F	Mild to moderate depressive symptoms as categorized by using a standardized depression/assessment tool (MDD)	CPT II
3354F	Clinically significant depressive symptoms as categorized by using a standardized depression screening/assessment tool (MDD)	CPT II
96127	Brief emotional/behavioral assessment with scoring and documentation using a standardized instrument	CPT

COA-FSA: Care for Older Adults - Functional Status Assessment

CareAdvantage
Reporting-Only

Metric Source: Rate 2 of HEDIS metric COA.

Patient Eligibility: Members 66 years and older.

Exclusions: Services provided in an acute inpatient setting.

Metric Definition: The percentage of adults 66 years and older who had functional status assessment during the measurement year.

Functional Status Assessment Procedure Codes

Code	Definition	Code System
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
1170F	Functional status assessed (COA) (RA)	CPT-II
99483	Under Cognitive Assessment and Care Plan Services	CPT

COA-PS: Care for Older Adults - Pain Screening

CareAdvantage
Payment

Metric Source: Rate 3 of HEDIS metric COA.

Patient Eligibility: Adults 66 years and older.

Exclusions: Services provided in an acute inpatient setting.

Metric Definition: The percentage of adults 66 years and older who had pain assessment during the measurement year.

Pain Screening Procedure Codes

Code	Definition	Code System
1125F	Pain severity quantified; pain present (COA) (ONC)	CPT-II
1126F	Pain severity quantified; no pain present (COA) (ONC)	CPT-II

COA-MR: Care for Older Adults – Medications Review

CareAdvantage
Payment

Metric Source: Rate 1 of HEDIS metric COA.

Patient Eligibility: Adults 66 years and older.

Exclusions: Services provided in an acute inpatient setting.

Metric Definition: The percentage of adults 66 years and older who had medication review during the measurement year.

Medication Review Procedure Codes

Code	Definition	Code System
1159F	Medication list documented in medical record (COA)	CPT-II
1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies & supplements) documented in the medical record (COA)	CPT-II
90863	Medication Review	CPT
99483	Medication Review	CPT
99495	Transitional Care Management Services	CPT
99496	Transitional Care Management Services	CPT
99605	Medication Review	CPT
99606	Medication Review	CPT
G8427	Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications	HCPCS

COA-Complete: Care for Older Adults - Complete

CareAdvantage
Reporting-Only

Metric Source: HPSM internal rate, based on meeting all three components of the HEDIS metric COA.

Patient Eligibility: Adults 66 years and older.

Metric Definition: The percentage of adults 66 years and older who had all of the following during the measurement year: functional status assessment, pain screening, and medications review.

COL: Colorectal Cancer Screening

CareAdvantage
Payment

Metric Source: HEDIS metric of the same name.

Patient Eligibility: Patients 50–75 years of age.

Exclusions:

- Exclude members who have had colorectal cancer or total colectomy
- Exclude Medicare members 66 years of age and older as of December 31 of the measurement year who are enrolled in an Institutional SNP (I-SNP) or living long-term in an institution at any time during the measurement year.
- Exclude members 66 years of age and older as of December 31 of the measurement year with frailty AND advanced illness.
- Exclude members receiving palliative care

Metric Definition: The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Colorectal Cancer Screening Procedure Codes

Code	Definition	Code System
G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous	HCPCS
G0104	Colorectal cancer screening; flexible sigmoidoscopy	HCPCS
G0105	Colorectal cancer screening; colonoscopy on individual at high risk	HCPCS
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	HCPCS
G0464	Colorectal cancer screening; stool-based dna and fecal occult hemoglobin (e.g., kras, ndrg4 and bmp3)	HCPCS
44388	Colonoscopy	CPT
44389	Colonoscopy	CPT
44390	Colonoscopy	CPT
44391	Colonoscopy	CPT
44392	Colonoscopy	CPT
44393	Colonoscopy	CPT
44394	Colonoscopy	CPT

44397	Colonoscopy	CPT
44401	Colonoscopy	CPT
44402	Colonoscopy	CPT
44403	Colonoscopy	CPT
44404	Colonoscopy	CPT
44405	Colonoscopy	CPT
44406	Colonoscopy	CPT
44407	Colonoscopy	CPT
44408	Colonoscopy	CPT
45330	Flexible Sigmoidoscopy	CPT
45331	Flexible Sigmoidoscopy	CPT
45332	Flexible Sigmoidoscopy	CPT
45333	Flexible Sigmoidoscopy	CPT
45334	Flexible Sigmoidoscopy	CPT
45335	Flexible Sigmoidoscopy	CPT
45337	Flexible Sigmoidoscopy	CPT
45338	Flexible Sigmoidoscopy	CPT
45339	Flexible Sigmoidoscopy	CPT
45340	Flexible Sigmoidoscopy	CPT
45341	Flexible Sigmoidoscopy	CPT
45342	Flexible Sigmoidoscopy	CPT
45345	Flexible Sigmoidoscopy	CPT
45346	Flexible Sigmoidoscopy	CPT
45347	Flexible Sigmoidoscopy	CPT
45349	Flexible Sigmoidoscopy	CPT
45350	Flexible Sigmoidoscopy	CPT
45355	Colonoscopy	CPT
45378	Colonoscopy	CPT
45379	Colonoscopy	CPT
45380	Colonoscopy	CPT
45381	Colonoscopy	CPT
45382	Colonoscopy	CPT
45383	Colonoscopy	CPT

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45391	Colonoscopy	CPT
45392	Colonoscopy	CPT
45393	Colonoscopy	CPT
45398	Colonoscopy	CPT
74261	CT Colonography	CPT
74262	CT Colonography	CPT
74263	CT Colonography	CPT
81528	CT Colonography	CPT
82270	FOBT Lab Test	CPT
82274	FOBT Lab Test	CPT

DAE: Use of High-Risk Medications in the Elderly - One Prescription

CareAdvantage
Reporting-Only

Metric Source: Rate 1 of the HEDIS metric DAE.

Patient Eligibility: Medicare members 66 years of age and older.

Metric Definition: The percentage of Medicare members 66 years of age and older who had at least two dispensing events for the same high-risk medication.

For a complete list of medications considered high-risk, please refer to: **https://www.hpsm.org/provider/value-based-payment**.

EED: Eye Exam for Patients with Diabetes

CareAdvantage
Reporting-Only

Metric Source: HEDIS metric of the same name (formerly Rate 4 of the retired HEDIS metric, CDC).

Patient Eligibility: Patients 18 -75 years old with a diagnosis of diabetes (types 1 or 2).

Exclusions:

- Members who have not had a diagnosis of diabetes AND had a diagnosis of gestational diabetes or steroid-induced diabetes during the current or prior measurement year
- Members 66 years and older as of December 31 of the measurement year with frailty AND advanced illness
- Members receiving palliative care

Metric Definition: Percent of diabetic patients who had screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the current calendar year.
- A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the current calendar year.
- Bilateral eye enucleation anytime during the member's history through December 31 of the current calendar year.

Diabetic Retinal Eye Exam Procedure Codes

Code	Definition	Code System
67028	Diabetic Retinal Screening	CPT
67030	Diabetic Retinal Screening	CPT
67031	Diabetic Retinal Screening	CPT
67036	Diabetic Retinal Screening	CPT
67039	Diabetic Retinal Screening	CPT
67040	Diabetic Retinal Screening	CPT
67041	Diabetic Retinal Screening	CPT
67042	Diabetic Retinal Screening	CPT
67043	Diabetic Retinal Screening	CPT
67101	Diabetic Retinal Screening	CPT

67105	Diabetic Retinal Screening	CPT
67107	Diabetic Retinal Screening	CPT
67108	Diabetic Retinal Screening	CPT
67110	Diabetic Retinal Screening	CPT
67113	Diabetic Retinal Screening	CPT
67121	Diabetic Retinal Screening	CPT
67141	Diabetic Retinal Screening	CPT
67145	Diabetic Retinal Screening	CPT
67208	Diabetic Retinal Screening	CPT
67210	Diabetic Retinal Screening	CPT
67218	Diabetic Retinal Screening	CPT
67220	Diabetic Retinal Screening	CPT
67221	Diabetic Retinal Screening	CPT
67227	Diabetic Retinal Screening	CPT
67228	Diabetic Retinal Screening	CPT
92002	Diabetic Retinal Screening	CPT
92004	Diabetic Retinal Screening	CPT
92012	Diabetic Retinal Screening	CPT
92014	Diabetic Retinal Screening	CPT
92018	Diabetic Retinal Screening	CPT
92019	Diabetic Retinal Screening	CPT
92134	Diabetic Retinal Screening	CPT
92225	Diabetic Retinal Screening	CPT
92226	Diabetic Retinal Screening	CPT
92227	Diabetic Retinal Screening	CPT
92228	Diabetic Retinal Screening	CPT
92230	Diabetic Retinal Screening	CPT

92235	Diabetic Retinal Screening	CPT
92240	Diabetic Retinal Screening	CPT
92250	Diabetic Retinal Screening	CPT
92260	Diabetic Retinal Screening	CPT
99203	Diabetic Retinal Screening	CPT
99204	Diabetic Retinal Screening	CPT
99205	Diabetic Retinal Screening	CPT
99213	Diabetic Retinal Screening	CPT
99214	Diabetic Retinal Screening	CPT
99215	Diabetic Retinal Screening	CPT
99242	Diabetic Retinal Screening	CPT
99243	Diabetic Retinal Screening	CPT
99244	Diabetic Retinal Screening	CPT
99245	Diabetic Retinal Screening	CPT
S0620	Diabetic Retinal Screening	HCPCS
S0621	Diabetic Retinal Screening	HCPCS
S3000	Diabetic Retinal Screening	HCPCS
3072F	Diabetic Retinal Screening Negative	CPT II
2022F	Diabetic Retinal Screening With Eye Care Professional	CPT II
2023F	Diabetic Retinal Screening With Eye Care Professional	CPT II
2024F	Diabetic Retinal Screening With Eye Care Professional	CPT II
2025F	Diabetic Retinal Screening With Eye Care Professional	CPTII
2026F	Diabetic Retinal Screening With Eye Care Professional	CPTII
2033F	Diabetic Retinal Screening With Eye Care Professional	CPT II
65091	Unilateral Eye Enucleation	CPT
65093	Unilateral Eye Enucleation	CPT
65101	Unilateral Eye Enucleation	CPT

65103	Unilateral Eye Enucleation	CPT
65105	Unilateral Eye Enucleation	CPT
65110	Unilateral Eye Enucleation	CPT
65112	Unilateral Eye Enucleation	CPT
65114	Unilateral Eye Enucleation	CPT
08B10ZX	Unilateral Eye Enucleation Left	ICD10PCS
08B10ZZ	Unilateral Eye Enucleation Left	ICD10PCS
08B13ZX	Unilateral Eye Enucleation Left	ICD10PCS
08B13ZZ	Unilateral Eye Enucleation Left	ICD10PCS
08B1XZX	Unilateral Eye Enucleation Left	ICD10PCS
08B1XZZ	Unilateral Eye Enucleation Left	ICD10PCS
08B00ZX	Unilateral Eye Enucleation Right	ICD10PCS
08B00ZZ	Unilateral Eye Enucleation Right	ICD10PCS
08B03ZX	Unilateral Eye Enucleation Right	ICD10PCS
08B03ZZ	Unilateral Eye Enucleation Right	ICD10PCS
08B0XZX	Unilateral Eye Enucleation Right	ICD10PCS
08B0XZZ	Unilateral Eye Enucleation Right	ICD10PCS

HBD-2: Hemoglobin A1c Control for Patients with Diabetes (>9.0%)

CareAdvantage
Payment

Metric Source: Rate 2 of the HEDIS metric of the same name (formerly Rate 2 of the retired HEDIS metric, CDC).

Patient Eligibility: Members 18 -75 years old with a diagnosis of diabetes (types 1 or 2).

Exclusions:

- Members who have not had a diagnosis of diabetes AND had a diagnosis of gestational diabetes or steroid-induced diabetes during the current or prior measurement year
- Members 66 years and older as of December 31 of the measurement year with frailty AND advanced illness
- Members receiving palliative care

Metric Definition: Percent of diabetic members whose most recent HbA1c level (performed during the current calendar year) is >9.0% as identified by automated laboratory data or administrative data if laboratory data is not received.

Laboratories who currently send data directly to HPSM on a monthly basis:

- Chinese Hospital
- San Mateo Medical Center
- LabCorp
- Quest
- North East Medical Services
- Stanford
- Sutter

*Note that lab data sent directly to HPSM by the sources listed above might still not be 100% complete. It is important to check your monthly reports and follow up with the lab provider to obtain any results for your patients.

Diabetes HbA1c Procedure Codes

Code	Definition	Code System
3044F	HbA1c Level Less Than 7.0	CPT-II
3045F	Most recent hemoglobin A1c (HbA1c) level 7.0-9.0% (DM)	CPT-II
3046F	Most recent hemoglobin A1c level greater than 9.0% (DM)	CPT-II
3051F	HbA1c Level greater than or equal to 7.0% and less than 8.0%	CPT-II
3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%	CPT-II

*To get credit towards this performance metric, lab data must be received directly or a CPT Category II Code must be submitted by the participating provider office once the lab result has been reviewed and documented in the patient's medical record.

HPC: Hospitalization for Potentially Preventable Complications

CareAdvantage
Reporting-Only

Metric Source: HEDIS metric of the same name.

Patient Eligibility: Members 67 and older.

Exclusions:

- Members enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
- Members living long-term in an institution any time during the measurement year.

Metric Definition: For members 67 years of age and older, the rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 members.

List of Ambulatory Care Sensitive Conditions (ACSC)

ACSC are acute or chronic health conditions that can be managed or treated in an outpatient setting. The ambulatory care conditions included in this metric are:

- Chronic ACSC
- Diabetes short-term complications.
- Diabetes long-term complications
- Uncontrolled diabetes
- Lower-extremity amputation among patients with diabetes
- COPD
- Asthma
- Hypertension
- Heart failure
- Acute ACSC
- Bacterial pneumonia
- Urinary tract infection
- Cellulitis
- Pressure ulcer

FLU: Seasonal Influenza Vaccine

CareAdvantage
Payment

Metric Source: HPSM internal metric.

Patient Eligibility: All members 6 months and older.

Exclusions: Exclude women with a diagnosis of pregnancy during the measurement period.

Metric Definition: The percentage of members 6 months and older receiving a seasonal flu vaccination July 1, 2023 through March 31, 2024.

Numerator: Assigned members (6 months and older) with flu vaccine administered July of the measurement year through March of the following calendar year *OR* evidence of flu vaccine from CAIR Registry administered July of the measurement year through March of the following calendar year.

Denominator: All assigned members (6 months and older) who had at least one in-person outpatient encounter with provider during July through December of the measurement year.

For a complete list of outpatient visit codes, please refer to **https://www.hpsm.org/provider/value-based-payment**.

Flu Vaccine Procedure Codes

Code	Definition	Code System
Q2034	Influenza virus vaccine, split virus, for intramuscular use (agriflu)	HCPCS
Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria)	HCPCS
Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval)	HCPCS
Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluvirin)	HCPCS
Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone)	HCPCS
Q2039	Influenza virus vaccine, not otherwise specified	HCPCS
G0008	Administration of influenza virus vaccine	HCPCS
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	CPT
90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use	CPT
90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use	CPT
90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use	CPT

90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use	CPT
90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use	CPT
90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use	CPT
90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use	CPT
90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	CPT
90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use	CPT
90673	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	CPT
90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	CPT
90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	CPT
90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use	CPT
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use	CPT
90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use	CPT
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use	CPT
90689	Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use	CPT
90694	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use	CPT
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use	CPT

PCR: Plan All-Cause Readmissions

CareAdvantage
Reporting-Only

Metric Source: HEDIS metric of the same name.

Patient Eligibility: Members 18 and older.

Exclusions:

- Exclude hospital stays for any of the following reasons from the denominator:
    - The member died during the stay.
    - Female members with a principal diagnosis of pregnancy
    - A principal diagnosis for a condition originating in the perinatal period
- Exclude hospital stays for any of the following reasons from the numerator:
    - Female members with a principal diagnosis of pregnancy
    - A principal diagnosis for a condition originating in the perinatal period
    - Planned admissions using any of the following:
        - A principal diagnosis of maintenance chemotherapy
        - A principal diagnosis of rehabilitation
        - An organ transplant
        - A potentially planned procedure without a principal acute diagnosis

Metric Definition: For members 18 years of age and older, the percentage of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

SBIRT: Substance Misuse Screening and Follow Up

CareAdvantage
Reporting-Only

Metric Source: HPSM internal metric.

Patient Eligibility: Members 12 years and older.

Metric Definition: The percentage of members 12 years and older who had an outpatient visit and received a substance misuse screening in the current calendar year.

For a complete list of outpatient visit codes, please refer to **https://www.hpsm.org/provider/value-based-payment**.

SBIRT Procedure Codes

Code	Definition	Code System
G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min	HCPCS
G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min	HCPCS
G0442	Prevention: Screening for alcohol misuse in adults including pregnant women once per year.	HCPCS
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	HCPCS
H0001	Alcohol and/or Drug Assessment	HCPCS
H0003	Alcohol and/or Drug Screening; Laboratory analysis of specimens for presence of alcohol and/or drugs	HCPCS
H0049	Alcohol and/or drug screening	HCPCS
3016F	Substance misuse screening	CPT-II
99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min	CPT
99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min	CPT

SDoH: Z-Coding for Social Determinants of Health

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Reporting-Only

Metric Source: HPSM internal metric.

Patient Eligibility: All assigned members.

Metric Definition: The percentage of assigned members who had at least one eligible z-code reported during the measurement year.

HPSM understands that medical care and healthcare services are one of many complex factors that influences members' health status. In order to create more holistic member profiles that consider other non-medical and environmental indicators of health, HPSM requests that providers assist in our collection of data on social determinants of health through select z-coding. HPSM uses z-codes to identify health inequities, determine eligibility for CalAIM services, and develop tailored interventions with community partners.

25 eligible z-codes for this metric capture factors relating to illiteracy, homelessness or housing insecurity, food or water insecurity, social exclusion or loneliness, domestic conflict, or incarceration are sourced from the Department of Health Care Services' (DHCS) list of priority z-codes for CalAIM's Population Health Management (PHM) initiative. For more information, see All Plan Letter 21-009. An additional nine z-codes are eligible for this metric to capture factors relating to reduced physical mobility or dependence on durable medical equipment (DME).

SDoH Eligible Z-Codes

Z-Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support

Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)
Z73.6	Limitation of activities due to disability
Z74.0	Reduced mobility
Z74.01	Bed confinement status
Z74.09	Other Reduced Mobility
Z99.0	Dependence on aspirator
Z99.1	Dependence on respirator
Z99.2	Dependence on renal dialysis
Z99.3	Dependence on wheelchair
Z99.8	Dependence on other enabling machines and devices

TRC-PE: Transitions of Care - Patient Engagement After Inpatient Discharge

CareAdvantage
Reporting-Only

Metric Source: Rate 3 of the HEDIS metric TRC.

Patient Eligibility: Members 18 and older

Metric Definition: The percentage of discharges for members 18 years of age and older that had documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.

For a complete list of outpatient visit codes, please refer to **https://www.hpsm.org/provider/value-based-payment**.

Additional Visit Procedure Codes

Code	Definition	Code System
98966	Telephone Visits	CPT
98967	Telephone Visits	CPT
98968	Telephone Visits	CPT
99441	Telephone Visits	CPT
99442	Telephone Visits	CPT
99443	Telephone Visits	CPT
99495	Transitional Care Management Services	CPT
99496	Transitional Care Management Services	CPT

TRC-MR: Transitions of Care - Medication Reconciliation Post-Discharge

CareAdvantage
Payment

Metric Source: Rate 4 of the HEDIS metric TRC.

Patient Eligibility: Members 18 and older

Metric Definition: The percentage of discharges for members 18 years of age and older who had documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Medication Reconciliation Procedure Codes

Code	Definition	Code System
1111F	Discharge medications reconciled with the current medication list in outpatient medical record (COA) (GER)	CPT-II
99483	Medication Reconciliation Encounter	CPT
99495	Medication Reconciliation Encounter	CPT
99496	Medication Reconciliation Encounter	CPT

IV . Health Education Resources that Support P4P

Some patients may benefit from additional health education support or information regarding health education topics or lifestyle changes in order to achieve health related goals and improve outcomes. We recognize that some health education topics or self-management education may require time and resources beyond what you may be able to cover in a clinic visit, especially when it comes to health topics such as obesity and weight management, diabetes self-management, controlling hypertension or other lifestyle influenced health conditions. HPSM's Health Education Guide online offers a wide variety of health information and tips for staying healthy. Members can access our Health Education Guide online at https://www.hpsm.org/health-information. Members who would benefit from health education resources or programs around topics such as maternal and child health, tobacco cessation services, and diabetes self-management can also call our Health Education line at **650-616-2165**.

If you need any other health education resources to support the care you provide to our members, please send us a request via email at healtheducationrequest@hpsm.org. We appreciate working in partnership with you in caring for our members.

V . Terms & Conditions

Participation in HPSM's P4P program, as well as acceptance of performance bonus payments, does not in any way modify or supersede any terms or conditions of any agreement between HPSM and participating providers. There is no guarantee of future funding or payment under any HPSM P4P performance bonus program. HPSM's P4P program and/or its terms and conditions may be modified or terminated at any time, with or without notice, at HPSM's sole discretion.

In consideration of HPSM's offering of its P4P program, provider agrees to fully and forever release and discharge HPSM from any and all claims, demands, causes of action, and suits, of any nature, pertaining to or arising from the offering by HPSM of the P4P Program. Any monies paid under the P4P program for services deemed inappropriately submitted will be recouped from future payment. All cases of suspected fraud or abuse will be investigated thoroughly and reported to the appropriate authorities. HPSM reserves the right to audit medical records to validate services have been completed as billed. If there is evidence of fraud, waste, or abuse, HPSM can recoup P4P payments found to be invalidly billed and the provider could lose privileges to participate in future HPSM P4P programs.

Participating providers must be in good standing with all contract and compliance requirements in order to receive HPSM P4P program payments. If any participating providers are not in good standing P4P program payments will not be made until such time that providers are meeting all contract and compliance requirements.

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