Benchmark Pay for Performance CareAdvantage Program Guidelines

2020 Program Year

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Updated January 13, 2020

Table of Contents

General Program Guidelines

Program Overview

Health Plan of San Mateo's Benchmark Pay for Performance (Benchmark P4P) program offers performance bonus payments to in-network CareAdvantage providers for targeted quality measures 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 measure set focuses on member access and preventive care services.

If you would like to participate in the program evaluation and update process in partnership with the Health Plan or if you have questions about the program, please contact the HPSM Provider Services Department at psinquiries@hpsm.org.

Provider Participation Eligibility

Providers must have an active CareAdvantage contract with HPSM and must have a specialty type designation as a primary care provider. The contract must be active as of the date of payment. Providers must have 50 HPSM CareAdvantage members assigned to their panel as of January 1st, 2020 to be eligible to participate.

Reports

Performance bonus payment in the Benchmark P4P program is contingent on meeting the specified measure benchmarks for assigned patients who meet the measure 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. The website for eReports login is: https://reports.hpsm.org

If you are unsure whether your organization has access, who in your organization has access, or would like to set up a log in to access the HPSM eReports system, please contact the HPSM Provider Services Department Monday 1 p.m. to 5 p.m., or Tuesday through Friday, 8 a.m. to 5 p.m. at **650-616-2106**, or email psinquiries@hpsm.org.

Payment Schedule

Final payment calculations for the Benchmark P4P program will be determined by April 30 following the program calendar year. 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. Payment methodology is outlined in these guidelines.

Payment Calculation

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

{(Member Points * $Benchmark P4P PMPM) + Full Credit Benchmark Bonus}
* # Assigned Metrics Factor Adjustment

Term Definitions

Member Points: Member Months * Composite Quality Score

Member Months: Total of all member months for members assigned to the CareAdvantage PCP panel for at least 9 months out of 12 during the calendar year. Does not require the 9 months of assignment to be continuous.

Composite Quality Score: Average score for all earned quality points based on final April 1 progress report calculation following the program calendar year. For quality points to be attributed to an assigned measure the participating provider must have at least 30 patients who meet the denominator criteria.

$Benchmark P4P PMPM: Specific per member per month rate determined by HPSM no later than April 30 following the program calendar year. Allocations determined based on 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 all full credit quality benchmarks are met in the program calendar year.

Assigned Metrics Factor Adjustment: Adjustment made based on the number of assigned quality metrics for the program calendar year.

Benchmark Scorecard Summary

Performance Measure	Measure Source	Full Credit Benchmark (2020)	Partial Credit Benchmark (2020)	Full Credit Quality Score	Partial Credit Quality Score	Payment	Reporting
Adult BMI Assessment	NCQA/HEDIS	98%	96%	2	1	X	
Ambulatory Care - ED Visits	NCQA/HEDIS	N/A	N/A	2	1		X
Care for Older Adults - Advance Care Planning	NCQA/HEDIS	48%	42%	2	1	X	
Care for Older Adults - Functional Status Assessment	NCQA/HEDIS	65%	61%	2	1	X	
Care for Older Adults - Pain Screening	NCQA/HEDIS	82%	78%	2	1	X	
Care for Older Adults - Medications Review	NCQA/HEDIS	80%	77%	2	1	X	
Care for Older Adults - Complete	NCQA/HEDIS	75%	60%	2	1		X
Colorectal Cancer Screening	NCQA/HEDIS	80%	75%	2	1	X	
Controlling High Blood Pressure	NCQA/HEDIS	70%	56%	2	1	X	
Depression Screening & Follow-up (12 y/o +)	HPSM	75%	60%	2	1	X	
Diabetes HbA1c Poor Control	NCQA/HEDIS	22%	25%	2	1	X	
Hospitalization for Potentially Preventable Complications	NCQA/HEDIS	74%	88%	2	1		X
Mammogram for Breast Cancer Screening	NCQA/HEDIS	67%	63%	2	1		X
Substance Misuse (SBIRT)	HPSM	75%	60%	2	1		X
Plan All-Cause Readmissions	NCQA/HEDIS	.85	.80	2	1		X
Transitions of Care - Patient Engagement After Inpatient Discharge	NCQA/HEDIS	91%	86%	2	1	X	
Transitions of Care - Medication Reconciliation Post-Discharge	NCQA/HEDIS	79%	68%	2	1	X	
Use of High-Risk Medications in the Elderly - One Prescription	NCQA/HEDIS	21%	19%	2	1		X

1 . Adult BMI Assessment (ABA)

Patient Eligibility: Patients 18-74 years old who had an outpatient visit

Exclude female members who have a diagnosis of pregnancy during the measurement year or the year prior to the measurement year.

Full Credit Benchmark: 98%

Partial Credit Benchmark: 96%

Measure Definition:

The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

BMI: Body mass index. A statistical measure of the weight of a person scaled according to height

BMI percentile: The percentile ranking based on the Centers for Disease Control and Prevention's (CDC) BMI-for-age growth charts, which indicate the relative position of a patient's BMI number among those of the same sex and age

ICD-10 BMI Diagnosis Codes

18-19 years old

Definition	Code System
[**Z68.51**] Body mass index (BMI) pediatric, less than 5th percentile for age	ICD10CM
[**Z68.52**] Body mass index (BMI) pediatric, 5th percentile to less than 85th percentile for age	ICD10CM
[**Z68.53**] Body mass index (BMI) pediatric, 85th percentile to less than 95th percentile for age	ICD10CM
[**Z68.54**] Body mass index (BMI) pediatric, greater than or equal to 95th percentile for age	ICD10CM

20+ years old

Code	Definition
Z68.1	[Z68.1] Body mass index (BMI) 19.9 or less, adult
Z68.20	[Z68.20] Body mass index (BMI) 20.0-20.9, adult
Z68.21	[Z68.21] Body mass index (BMI) 21.0-21.9, adult
Z68.22	[Z68.22] Body mass index (BMI) 22.0-22.9, adult
Z68.23	[Z68.23] Body mass index (BMI) 23.0-23.9, adult
Z68.24	[Z68.24] Body mass index (BMI) 24.0-24.9, adult
Z68.25	[Z68.25] Body mass index (BMI) 25.0-25.9, adult

Code	Definition
Z68.26	[Z68.26] Body mass index (BMI) 26.0-26.9, adult
Z68.27	[Z68.27] Body mass index (BMI) 27.0-27.9, adult
Z68.28	[Z68.28] Body mass index (BMI) 28.0-28.9, adult
Z68.29	[Z68.29] Body mass index (BMI) 29.0-29.9, adult
Z68.30	[Z68.30] Body mass index (BMI) 30.0-30.9, adult
Z68.31	[Z68.31] Body mass index (BMI) 31.0-31.9, adult
Z68.32	[Z68.32] Body mass index (BMI) 32.0-32.9, adult
Z68.33	[Z68.33] Body mass index (BMI) 33.0-33.9, adult
Z68.34	[Z68.34] Body mass index (BMI) 34.0-34.9, adult
Z68.35	[Z68.35] Body mass index (BMI) 35.0-35.9, adult
Z68.36	[Z68.36] Body mass index (BMI) 36.0-36.9, adult
Z68.37	[Z68.37] Body mass index (BMI) 37.0-37.9, adult
Z68.38	[Z68.38] Body mass index (BMI) 38.0-38.9, adult
Z68.39	[Z68.39] Body mass index (BMI) 39.0-39.9, adult
Z68.41	[Z68.41] Body mass index (BMI) 40.0-44.9, adult
Z68.42	[Z68.42] Body mass index (BMI) 45.0-49.9, adult
Z68.43	[Z68.43] Body mass index (BMI) 50-59.9 , adult
Z68.44	[Z68.44] Body mass index (BMI) 60.0-69.9, adult
Z68.45	[Z68.45] Body mass index (BMI) 70 or greater, adult

2 . Ambulatory Care - ED Visits (AMB)

Patient Eligibility: All members excluding those in hospice.

Do not include ED visits that result in an inpatient stay. Exclude visits for mental health or chemical dependency.

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

Measure Definition: This measure summarizes utilization of ambulatory care in the following categories: ED 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.

3 . Care for Older Adults - Advance Care Planning (COA)

Patient Eligibility: Adults 66 years and older

Full Credit Benchmark: 48%

Partial Credit Benchmark: 42%

Measure Definition: The percentage of adults 66 years and older who had advance care planning during the measurement year.

Advance Care Planning Procedure Codes

Code	Definition	Code System
99483	Advance Care Planning	CPT
99497	Advance Care Planning	CPT
1123F	Advance Care Planning discussed and documented advance care plan or surrogate decision maker documented in the medical record (DEM) (GER, Pall Cr)	CPT-CAT-II
1124F	Advance Care Planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan (DEM) (GER, Pall Cr)	CPT-CAT-II
1157F	Advance care plan or similar legal document present in the medical record (COA)	CPT-CAT-II
1158F	Advance care planning discussion documented in the medical record (COA)	CPT-CAT-II
S0257	Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service) (S0257)	HCPCS
Z66	[Z66] Do not resuscitate	ICD10CM

4 . Care for Older Adults - Functional Status Assessment (COA)

Patient Eligibility: Adults 66 years and older

Full Credit Benchmark: 65%

Partial Credit Benchmark: 61%

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

Exclude services provided in an acute inpatient setting

Functional Status Assessment Procedure Codes

Code	Definition	Code System
99483		CPT
1170F	Functional status assessed (COA) (RA)	CPT-CAT-II
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit (G0438)	HCPCS
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit (G0439)	HCPCS

5 . Care for Older Adults - Pain Screening (COA)

Patient Eligibility: Adults 66 years and older

Full Credit Benchmark: 82%

Partial Credit Benchmark: 78%

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

Exclude services provided in an acute inpatient setting

Pain Screening Procedure Codes

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

6 . Care for Older Adults - Medications Review (COA)

Patient Eligibility: Adults 66 years and older

Full Credit Benchmark: 80%

Partial Credit Benchmark: 77%

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

Exclude services provided in an acute inpatient setting.

Medication Review Procedure Codes

Code	Definition	Code System
1159F	Medication list documented in medical record (COA)	CPT-CAT-II
G8427	Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications (G8427)	HCPCS
90863	Medication Review	CPT
99483	Medication Review	CPT
99605	Medication Review	CPT
99606	Medication Review	CPT
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-CAT-II
99495	Transitional Care Management Services	CPT
99496	Transitional Care Management Services	CPT

7 . Care for Older Adults - Complete (COA)

Patient Eligibility: Adults 66 years and older

Full Credit Benchmark: 75%

Partial Credit Benchmark: 60%

Measure Definition: The percentage of adults 66 years and older who had all of the following during the measurement year: advance care planning, medication review, functional status assessment, and pain assessment.

8 . Colorectal Cancer Screening (COL)

Patient Eligibility: Patients 50–75 years of age

Exclusion criteria:

Exclude members who have had:

- Colorectal cancer
- Total colectomy

Exclude Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:

- Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
- Living long-term in an institution any time during the measurement year

Exclude members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness.

Full Credit Benchmark: 80%

Partial Credit Benchmark: 75%

Measure 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
82270	FOBT Lab Test	CPT
82274	FOBT Lab Test	CPT
G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous (G0328)	HCPCS
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

Code	Definition	Code System
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
G0104	Colorectal cancer screening; flexible sigmoidoscopy (G0104)	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
45355	Colonoscopy	CPT

Code	Definition	Code System
45378	Colonoscopy	CPT
45379	Colonoscopy	CPT
45380	Colonoscopy	CPT
45381	Colonoscopy	CPT
45382	Colonoscopy	CPT
45383	Colonoscopy	CPT
45384	Colonoscopy	CPT
45385	Colonoscopy	CPT
45386	Colonoscopy	CPT
45387	Colonoscopy	CPT
45388	Colonoscopy	CPT
45389	Colonoscopy	CPT
45390	Colonoscopy	CPT
45391	Colonoscopy	CPT
45392	Colonoscopy	CPT
45393	Colonoscopy	CPT
45398	Colonoscopy	CPT
G0105	Colorectal cancer screening; colonoscopy on individual at high risk (G0105)	HCPCS
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk (G0121)	HCPCS
74261	CT Colonography	CPT
74262	CT Colonography	CPT
74263	CT Colonography	CPT
81528	CT Colonography	CPT
G0464	Colorectal cancer screening; stool-based dna and fecal occult hemoglobin (e.g., kras, ndrg4 and bmp3) (G0464)	HCPCS

9 . Controlling High Blood Pressure (CBP)

Patient Eligibility: Members 18-85 years old who had at least two visits and a diagnosis of hypertension during the measurement year or the year prior to the 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.

Full Credit: 70%

Partial Credit: 56%

Measure 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.

Representative BP : The most recent BP reading during the measurement year on or after the second diagnosis of hypertension

ICD10 Diagnosis Code for Hypertension

Code	Definition	Code System
I10	[I10] Essential (primary) hypertension	ICD10CM

Codes for Blood Pressure

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

10 . Depression Screening and Follow-up (ages 12+) (CDF)

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.

A patient is not eligible if they have a documented active diagnosis or depression or bipolar disorder.

Full Credit: 75%

Partial Credit: 60%

Measure 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 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

Depression Screening Procedure Codes

59400	Depression Screening	CPT
59510	Depression Screening	CPT
59610	Depression Screening	CPT
59618	Depression Screening	CPT
90791	Depression Screening	CPT
90792	Depression Screening	CPT
90832	Depression Screening	CPT
90834	Depression Screening	CPT
90837	Depression Screening	CPT
92625	Depression Screening	CPT
96116	Depression Screening	CPT
96118	Depression Screening	CPT
96150	Depression Screening	CPT
96151	Depression Screening	CPT
97165	Depression Screening	CPT
97166	Depression Screening	CPT
97167	Depression Screening	CPT
99201	Depression Screening	CPT
99202	Depression Screening	CPT

99203	Depression Screening	CPT
99204	Depression Screening	CPT
99205	Depression Screening	CPT
99212	Depression Screening	CPT
99213	Depression Screening	CPT
99214	Depression Screening	CPT
99215	Depression Screening	CPT
99384	Depression Screening	CPT
99385	Depression Screening	CPT
99386	Depression Screening	CPT
99387	Depression Screening	CPT
99394	Depression Screening	CPT
99395	Depression Screening	CPT
99396	Depression Screening	CPT
99397	Depression Screening	CPT
G0101	Depression Screening	HCPCS
G0402	Depression Screening	HCPCS
G0438	Depression Screening	HCPCS
G0439	Depression Screening	HCPCS
G0444	Depression Screening	HCPCS
G0502	Depression Screening	HCPCS
G0503	Depression Screening	HCPCS
G0504	Depression Screening	HCPCS
G0505	Depression Screening	HCPCS
G0507	Depression Screening	HCPCS
G8431	Depression Screening	HCPCS
G8510	Depression Screening	HCPCS
G8431	Screening for depression is documented as being positive and a follow-up plan is documented	HCPCS
G8510	Screening for depression is documented as negative, a follow-up plan is not required	HCPCS

11 . Diabetes HbA1c - Poor Control (CDC)

Patient Eligibility: Patients 18 years old and up with a diagnosis of diabetes

Exclusion Criteria:

- Members 66 years and older as of December 31 of the measurement year who meet any of the following criteria:
    - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
    - Living long-term in an institution any time during the measurement year
    - Have advanced illness ***and*** frailty
- Members who do not have a diagnosis of diabetes any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.

Full Credit: 22%

Partial Credit: 25%

Measure Definition: Percent of diabetic patients 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.

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

- Seton
- San Mateo Medical Center
- LabCorp
- Quest
- North East Medical Services

Diabetes HbA1c Procedure Codes

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

*To get credit towards this performance measure 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.

12 . Hospitalization for Potentially Preventable Complications (HPC)

Patient Eligibility: Members 67 and older

Exclusion Criteria:

- 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.

Full Credit: 74%

Partial Credit: 88%

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

ACSC **Ambulatory care sensitive condition.**
An acute or chronic health condition that can be managed or treated in an outpatient setting. The ambulatory care conditions included in this measure 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

13 . Mammogram for Breast Cancer Screening (BCS)

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

Exclusion criteria:
Medicare members 66 years of age and older by the end of the Measurement Period who meet either of the following:

- Enrolled in an Institutional SNP (I-SNP) any time during the Measurement Period.
- Living long-term in an institution any time during the Measurement Period.

Members 66 years of age and older by the end of the Measurement Period, with frailty and advanced illness

Full Credit: 67%

Partial Credit: 63%

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

Mammography Procedure Codes

Code	Definition	Code System
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
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

Mammography Exclusion Codes

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

14 . Substance Misuse (SBIRT)

Patient Eligibility: Patients 12 years old and up

Full Credit: 75%

Partial Credit: 60%

Measure Definition: The percentage of patients 12 years old and up who received a substance misuse screening in the current calendar year.

Procedure Codes

Code	Definition	Code System
99408	Alcohol and/or substance abuse structured screening & brief intervention services; 15 to 30min	CPT
99409	Alcohol and/or substance abuse structured screening & brief intervention services; greater than 30min	CPT
G0396	Alcohol and/or substance abuse structured screening & brief intervention services; 15 to 30min	HCPCS
G0397	Alcohol and/or substance abuse structured screening & brief intervention services; greater than 30min	HCPCS
G0442	Prevention: Screening for alcohol misuse in adults including pregnant women once per year.	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
H0050	Alcohol and/or drug service, brief intervention, per 15 min	HCPCS
3016F	Substance misuse screening	CPT CAT II

15 . Plan All-Cause Readmissions (PCR)

Patient Eligibility: Members 18 and older

Full Credit: .80

Partial Credit: .85

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

16 . Transitions of Care - Patient Engagement After Inpatient Discharge (TRC)

Patient Eligibility: Members 18 and older

Full Credit: 79%

Partial Credit: 68%

Measure 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.

> Download the Outpatient Visit Code List from hpsm.org

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

17 . Transitions of Care - Medication Reconciliation Post-Discharge (TRC)

Patient Eligibility: Members 18 and older

Full Credit: 91%

Partial Credit: 86!

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

18 . Use of High-Risk Medications in the Elderly - One Prescription (DAE)

Patient Eligibility: Medicare members 66 years of age and older

Full Credit: 21%

Partial Credit: 19%

Measure 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.

Medication Lists

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.

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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