Benchmark Pay for Performance

CareAdvantage Program Guidelines

2021 Program Year

Version 2

We value your feedback

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Version History

Version 2 Revisions – Effective 09/01/2021

1. **CDF (Depression Screening & Follow-Up):** Code set for numerator compliance expanded to include additional eligible procedure codes to match those of Medi-Cal P4P Program and prior year allowances.

2. **FLU (Seasonal Influenza Vaccine):** Flu vaccines administered July 1, 2021 through March 31, 2022 will be counted for credit in the 2021 program— this expands the original DOS of August 1 — December 31, 2021. Note that given the estimated three-month claims lag, providers may have to attest to any compliant members missing from the April 2022 eReports.

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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 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 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, 2021 to be eligible to participate.

Quality Measure Selection

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

- Prior year network performance
- Association between clinical process improvements and improved population health outcomes
- Population health needs of HPSM members
- Provider input
- Regulatory requirements

Data Reports and Additional Coding Resources

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 at: 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*	Description
Program Year	01/01/2021 – 12/31/2021	This is the anchor program year for all dates of service (DOS). For measures with a lookback period of multiple years, include 2021 DOS as the first year.
Claims Submission Deadline	03/31/2022	All HPSM claims and qualifying reporting codes must be submitted by this date to quality for payment credit.
Attestation Period	04/02/2022 – 04/30/2022	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 2022.
Payment Finalization	05/01/2022 – 06/30/2022	HPSM compiles all performance data submissions and calculates a payment using the formula below. Incentive payments are distributed via lump sum in the form of a check mailed to the primary mailing address on file.

*Subject to change

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

Term Definitions

Eligible 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. *Members receiving hospice services are excluded from P4P performance and rate calculations.

Composite Quality Score: Average score for all earned quality points based on final performance rate following the program calendar year. For quality points to be attributed to an assigned measure, the participating provider must have at minimum number of eligible patients in the denominator.

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

II . CareAdvantage Quality Measure Summary

CareAdvantage Payment Quality Measure Set

Provider performance in the payment measures below relative to the full and partial credit benchmarks earn quality score points used to generate a Composite Quality Score for incentive payments:

Shorthand*	Payment Measure Name	Measure Source	Performance Benchmarks *(Quality Score Points)*	
			Full Credit	Partial Credit
CBP	Controlling High Blood Pressure	HEDIS	72% (2)	67% (1)
CDC-Poor	Diabetes HbA1c Poor Control (≥9%)	HEDIS	15% (2) **Lower is better**	21% (1) **Lower is better**
CDF	Depression Screening & Follow Up	DHCS	75% (2)	60% (1)
COA-ACP	Care for Older Adults – Advance Care Planning	HEDIS	70% (2)	62% (1)
COA-FSA	Care for Older Adults – Functional Status Assessment	HEDIS	85% (2)	76% (1)
COA-MR	Care for Older Adults – Medications Review	HEDIS	60% (2)	45% (1)
COA-PS	Care for Older Adults – Pain Screening	HEDIS	69% (2)	61% (1)
COL	Colorectal Screening	HEDIS	80% (2)	75% (1)
FLU	Seasonal Influenza Vaccine	HPSM	75% (2)	69% (1)
TRC-PE	Transitions of Care – Patient Engagement After Inpatient Discharge	HEDIS	88% (2)	85% (1)

*Shorthand is used to identify measure in eReports

CareAdvantage Reporting-Only Quality Measure Set

HPSM collects performance data on the measures below. Reporting-only measures are not eligible for inclusion in payment calculations but are subject for inclusion as payment measures 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 Measure Name	Measure Source
AMB-ED	Ambulatory ED Visits	HEDIS

Avoid-ED	Avoidable ED Visits	HPSM
COA-Complete	Care for Older Adults – Complete	HEDIS
DAE	Use of High-Risk Medications in the Elderly – One Prescription	HEDIS
PCR	Plan All-Cause Readmissions	HEDIS
SBIRT	Substance Misuse Screening & Follow Up	HPSM
TRC-MR	Transitions of Care – Medication Reconciliation Post-Discharge	HEDIS

III . Quality Measure Specifications

AMB-ED: Ambulatory Care Emergency Visits

Reporting-Only

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 measure. HPSM's network rates will be reported back to providers.

Measure Definition: This measure 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

Reporting-Only

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

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

Measure 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.

CBP: Controlling High Blood Pressure

Payment

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

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. 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
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

CDC-Poor: Diabetes HbA1c Poor Control

Payment

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

Exclusions:

- 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 in 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.

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

*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
83036		CPT
83037		CPT
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
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 documented in the patient's medical record.

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

Payment

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.

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 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 measure, 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
96127	Brief emotional/behavioral assessment with scoring and documentation using a standardized instrument	CPT
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
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
1220F	Patient screened for depression (SUD)	CPT II
0545F	Plan for follow-up care for major depressive disorder documented (MDD ADOL)	CPT II

COA-ACP: Care for Older Adults - Advance Care Planning

Payment

Patient Eligibility: Members 66 years and older

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)	HCPCS
Z66	Do not resuscitate	ICD10CM

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

Payment

Patient Eligibility: Members 66 years and older

Exclusions: Services provided in an acute inpatient setting.

Measure 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
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	HCPCS
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	HCPCS

COA-PS: Care for Older Adults - Pain Screening

Payment

Patient Eligibility: Adults 66 years and older

Exclusions: Services provided in an acute inpatient setting

Measure 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-CAT-II
1126F	Pain severity quantified; no pain present (COA) (ONC)	CPT-CAT-II

COA-MR: Care for Older Adults - Medications Review

Payment

Patient Eligibility: Adults 66 years and older

Exclusions: Services provided in an acute inpatient setting.

Measure 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-CAT-II
G8427	Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications	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

COA-Complete: Care for Older Adults - Complete

Reporting-Only

Patient Eligibility: Adults 66 years and older

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

COL: Colorectal Cancer Screening

Payment

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

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	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
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	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
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	HCPCS
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	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)	HCPCS

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

Reporting-Only

Patient Eligibility: Medicare members 66 years of age and older

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.

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

HPC: Hospitalization for Potentially Preventable Complications

Payment

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.

Measure 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 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

FLU: Seasonal Influenza Vaccine

Payment

Patient Eligibility: All members 6 months and older.

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

Measure Definition: The percentage of members 6 months and older receiving a seasonal flu vaccination July 1, 2021 through March 31, 2022.

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
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
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

PCR: Plan All-Cause Readmissions

Reporting-Only

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

Measure 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

Reporting-Only

Patient Eligibility: Members 12 years and older

Measure 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
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
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 CAT II

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

Payment

Patient Eligibility: Members 18 and older

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.

> For a complete list of qualifying 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

Reporting-Only

Patient Eligibility: Members 18 and older

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

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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