Benchmark Pay-for-Performance Incentive

CareAdvantage Guidelines

2026 Measurement Year - Initial Release

Click on blue underlines throughout to jump to relevant section.

You may be looking for Care Gap Pay-for-Performance Incentive Program Guidelines, administered through Stellar Health.

MY2026 - Updated January 1, 2026

Summary of Changes to 2026 **CareAdvantage** Benchmark Pay-for-Performance ("Benchmark P4P")

Minimum number of patients in the denominator changed to ten (10) for the metric to be included in the composite quality score.

CareAdvantage Incentive-eligible Quality Metric Set

Changed

1. **Depression Screening and Follow-up (12 years and older) (DSF-E)** has been separated to reflect the two associated actions of screening and follow-up for a positive screen. Depression Screening (DSF-E-1) is incentive-eligible.

CareAdvantage Reporting-only Quality Metric Set

Changed

1. **Depression Screening and Follow-up (12 years and older) (DSF-E)** has been separated to reflect the two associated actions of screening and follow-up for a positive screen. Follow-up for a positive screen (DSF-E-2) will be a reporting-only metric.

Additional details will be provided following the National Committee for Quality Assurance's (NCQA) anticipated March 2026 release of Healthcare Effectiveness Data and Information Set (HEDIS) Technical Specifications.

Table of Contents

I. Overview

Health Plan of San Mateo's (HPSM) Benchmark Pay-for-Performance Incentive ("Benchmark P4P" or "incentive") shares data with in-network CareAdvantage providers regarding assigned HPSM patients and offers incentives for achieving targeted quality metrics to improve population health outcomes. The quality performance metric sets focus on member access and preventive care services.

Questions about Benchmark P4P 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 for incentive eligibility if they meet all the following criteria:

1. Clinic must have an active CareAdvantage primary care contract with HPSM for the entire duration between January 1, 2026 and June 30, 2026;
2. Clinic and/or associated medical group must have a minimum of 50 HPSM CareAdvantage members assigned to their panel for the entire duration of the 2026 calendar year (i.e., January 1, 2026 through December 31, 2026).
3. Clinic and/or associated medical group is not currently opted into the Care Gap Pay-for-Performance Incentive ("Care Gap P4P"), administered by Stellar Health.
4. Completed the *HPSM Primary Care Incentive Enrollment Forms* prior to the beginning of the measurement period. Contact PSInquiries@hpsm.org if you have questions regarding this requirement.

Quality Metric Selection

Quality metrics are selected for inclusion in Benchmark P4P based on several 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

Benchmarks and Improvement Targets

Standard Benchmarks

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

- National performance benchmarks
- Prior year network performance
- Critical mass thresholds for population health management

Benchmarks may be adjusted in the event no clinic meets the full credit benchmark. Decisions to amend benchmarks are made during the incentive bonus calculation process after conclusion of the data submission period and at the sole discretion of HPSM.

Improvement Targets

Clinics can receive partial credit for any quality metric in which their performance improves by an established margin compared to the prior Benchmark P4P Measurement Year (MY). A minimum 10% improvement "on the negative" is required to earn partial credit, when partial credit benchmark is not otherwise reached.

- Example A: If MY2025 rate = 10%, then MY2026 partial credit would be awarded for ≥19 % (10% improvement on 90% non-compliance)
- Example B: If MY2025 rate = 90%, then MY2026 partial credit would be awarded for ≥91 % (10% improvement on 10% non-compliance)

Data Reports and Additional Coding Resources

Performance bonus in Benchmark P4P is contingent on meeting specified metric benchmarks for assigned patients who meet the metric criteria. Once encounter information has been received and eligibility has been determined by HPSM, providers get credit toward the annual metric benchmark. Monthly progress reports are available to providers through the HPSM eReports portal. These progress reports summarize the clinic's progress to each metric benchmark and provide member-level details to support action to close relevant care gaps. Reports for the 2026 Measurement Year are published **at the beginning of each month between September 2026 and April 2026.** The website for eReports login is: https://reports.hpsm.org. Additional resources, including an eReports User Guide and code lists are available at: https://www.hpsm.org/provider/incentive-payments.

Timeline

Period	Dates (subject to change)	Description
Measurement Year	01/01/2026 – 12/31/2026	This is the anchor year for all dates of service (DOS). For metrics with a lookback period of multiple years, count 2026 as year 1.
Supplemental Data Submission Deadline	03/26/2026*	All supplemental data (e.g., EMR extracts, lab submissions) must be submitted by this date to ensure inclusion for incentive calculation.
Claims Submission Deadline	03/26/2026	All HPSM claims and qualifying codes must be submitted by this date to ensure inclusion for incentive calculation.
Attestation Period	04/01/2026 – 04/30/2026	Providers may manually attest for compliance for select metrics where the claims submission process is known to not capture all relevant data. Instructions for attestation are distributed each Spring and available on the HPSM Provider Incentives webpage.
Bonus Payment Finalization	06/01/2026 – 07/31/2026	HPSM compiles all performance data and calculates bonus payment as explained in the 'Incentive Bonus Calculation Formula' section. Bonus is distributed as a single electronic payment or check mailed to the financial address on file.

*March 26 is the cut-off date for HPSM to receive established and validated files from providers. December 31 of the measurement year is the cut-off date for files being received by HSPM for the first time.

Incentive Bonus Calculation Formula

Final Benchmark P4P bonus 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 or associated medical group for at least 9 months during the calendar year.

- Nine (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 eligible member months.

Composite Quality Score: Average (i.e., mean) score for all earned quality points based on final performance rates following the data submission period. **For MY2026, 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 ten (10) eligible patients in the denominator. If fewer than ten eligible patients in the denominator, the provider is considered ineligible for that metric and it is excluded from their composite quality score calculation.

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

Full Credit Benchmark Bonus: Potential 25% additional bonus amount added if the clinic or associated medical group meets all full credit benchmarks for its assigned track's quality metric set in the measurement year.

HPSM sets an earnings ceiling which is calculated utilizing the maximum potential composite quality score and network-standard capitation rates, plus the 25% additional Full Credit Benchmark Bonus.

II . CareAdvantage Quality Metric Summary

Exclusions: Members receiving hospice at any time during the measurement period are excluded from all metrics.

CareAdvantage Incentive-eligible Quality Metric Set

Clinics earn quality score points for each Incentive-eligible Metric in which their performance meets or exceeds the full or partial credit benchmark. For all MY2026 Incentive-eligible Metrics, full credit nets two (2) quality score points and partial credit nets one (1) point. See 'Incentive Payment Bonus Calculation Formula' section for details. Performance benchmarks released each Summer following the conclusion of prior year data collection.

Shorthand	Incentive-eligible Metric Name	Metric Source	Performance Benchmarks	
			Full Credit	Partial Credit[i]
BCS-E	Breast Cancer Screening	NCQA HEDIS	75%**	67%**
CBP	Controlling High Blood Pressure	NCQA HEDIS	75%**	72%**
COA-FSA	Care for Older Adults – Functional Status Assessment	NCQA HEDIS	90%**	87%**
COA-MR	Care for Older Adults – Medications Review	NCQA HEDIS	71%**	65%**
COL-E	Colorectal Cancer Screening	NCQA HEDIS	75%**	65%**
DSF-E-1	Depression Screening (12 years and older)	HPSM	62%**	49%**
EED	Eye Exam for Patients with Diabetes	NCQA HEDIS	77%**	70%**
FLU	Seasonal Influenza Vaccine	HPSM	81%**	74%**
GSD-2*	Hemoglobin A1c Control (>9.0%) for Patients with Diabetes	NCQA HEDIS	25%**	30%**
TRC-MR	Transitions of Care – Medications Reconciliation Post-Discharge	NCQA HEDIS	57%**	49%**

**Inverted metric; lower rate indicates better performance.*

***In this Initial Release, benchmarks are approximate. Benchmarks will be finalized with the Final Release.*

[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 and monitors performance data on "reporting-only" metrics. Reporting-only metrics are not included in incentive calculations but are subject for inclusion as incentive-eligible metrics in future P4P measurement years. While provider performance is not measured against benchmarks, HPSM shares back prior year network performance data to encourage performance improvement.

Shorthand	Reporting-only Metric Name	Metric Source
ACP	Advance Care Planning	NCQA HEDIS
Avoid-ED*	Avoidable Emergency Department Visits	NCQA HEDIS
DAE*	Use of High-Risk Medications in the Elderly – One Prescription	NCQA HEDIS
DSF-E-2	Follow-up After a Positive Depression Screen (12 years and older)	HPSM
HPC*	Hospitalization for Potentially Preventable Complications	NCQA HEDIS
PCR*	Plan All-Cause Readmissions	NCQA 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	NCQA HEDIS

**Inverted metric; lower rate indicates better performance.*

III . Quality Metric Specifications

ACP: Advance Care Planning

CareAdvantage
Reporting-only

Source: NCQA HEDIS MY2026 metric of the same name.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM CareAdvantage members 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.

Denominator: Assigned HPSM CareAdvantage members 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 during the measurement year.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

Numerator: Members meeting denominator inclusion criteria from whom HPSM has received sufficient evidence that advance care planning was completed prior to or during the measurement year.

Avoid-ED: Avoidable Emergency Department Visits

CareAdvantage
Reporting-only

Source: HPSM internal metric.

Type: Percentage.

Aim: Lower percentage indicates quality performance.

Definition: The percentage of avoidable emergency department (ED) visits among assigned HPSM CareAdvantage members.

Denominator: Assigned HPSM CareAdvantage members with an ED visit during the measurement period.

Numerator: Members meeting denominator inclusion criteria whose primary diagnosis for the ED visit HPSM qualifies as an 'avoidable ED visit'.

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

BCS-E: Breast Cancer Screening

CareAdvantage
Incentive-eligible

Source: NCQA HEDIS MY2026 metric of the same name.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM CareAdvantage members 50–74 years of age recommended for routine breast cancer screening who had a mammogram to screen for breast cancer.

Denominator: Assigned HPSM CareAdvantage members 50-74 years of age recommended for routine breast cancer screening.

Exclusions:

- Members who had a bilateral mastectomy or both right and left unilateral mastectomies prior to the end of the measurement period.
- Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria prior to the end of the measurement period.
- Members excluded from mammography for documented medical reasons.

Mammography Exclusion Code

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

Numerator: Members meeting denominator inclusion criteria for whom HPSM received one of the following procedure codes within the measurement period.

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
Incentive-eligible

Source: NCQA HEDIS MY2026 metric of the same name.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM CareAdvantage members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Denominator: HPSM CareAdvantage members 18-85 years of age who had at least two visits (outpatient, telephone, e-visit, or virtual) on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year.

Exclusions:

- Members with a diagnosis that indicates end-stage renal disease (ESRD) on or prior to December 31 of the measurement year.
- Members with a procedure that indicates ESRD: dialysis, nephrectomy, or kidney transplant on or prior to December 31 of the measurement year.
- Members with a diagnosis of pregnancy any time during the measurement year.
- Members who had a nonacute inpatient admission during the measurement year.

Numerator: Members meeting denominator inclusion criteria for whom the most recent BP reading taken in an outpatient setting during the measurement year is <140/90 mm Hg. The representative BP reading must be taken on or after the date of the second diagnosis of hypertension.

- The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).
- If there are multiple BPs on the same date of service, the lowest systolic and lowest diastolic BP are used.

Hypertension Diagnosis Code

Code	Definition	Code System
I10	Essential (primary) hypertension	ICD10CM

Blood Pressure Reading Codes

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

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

CareAdvantage
Incentive-eligible

Source: Rate 2 of NCQA HEDIS MY2026 measure COA.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM CareAdvantage members 66 years of age and older who had a functional status assessment during the measurement year.

Denominator: HPSM CareAdvantage members 66 years of age and older.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

Numerator: Members meeting denominator inclusion criteria for whom HPSM receives sufficient documentation that a functional status assessment was completed during the measurement year as evidenced by one of the following:

- At least one functional status assessment completed.
- Documentation within the medical record including evidence of a complete functional status assessment and the date when it was performed.
    - Notations for a complete functional status assessment must include one of the following:
        - Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.
        - Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.
        - Result of assessment using a standardized functional status assessment tool, not limited to:
            - SF-36®.
            - Assessment of Living Skills and Resources (ALSAR).

- Barthel ADL Index Physical Self-Maintenance (ADLS) Scale©.
- Bayer ADL (B-ADL) Scale.
- Barthel Index©.
- Edmonton Frail Scale©.
- Extended ADL (EADL) Scale.
- Groningen Frailty Index.
- Independent Living Scale (ILS).
- Katz Index of Independence in ADL©.
- Kenny Self-Care Evaluation.
- Klein-Bell ADL Scale.
- Kohlman Evaluation of Living Skills (KELS).
- Lawton & Brody's IADL scales©.
- Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales©.

Additional numerator exclusions:

- Comprehensive functional status assessments performed in an acute inpatient setting.

NOTE: A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment.

NOTE: The components of the functional status assessment numerator may take place during separate visits within the measurement year.

NOTE: The Functional Status Assessment indicator does not require a specific setting; therefore, services rendered during a telephone visit, e-visit or virtual check-in meet criteria.

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-MR: Care for Older Adults – Medications Review

CareAdvantage
Incentive-eligible

Source: Rate 1 of NCQA HEDIS MY2026 measure COA.

Type: Percentage

Aim: Higher percentage indicates quality performance.

Application: Benchmark credit will be applied for this metric. HPSM's network rates will be reported back to providers.

Definition: The percentage of assigned HPSM CareAdvantage members 66 years of age and older who had a medication review during the measurement year.

Denominator: Assigned HPSM CareAdvantage members 66 years of age and older.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

Numerator: Members meeting denominator inclusion criteria for whom HPSM receives sufficient documentation that a functional status assessment was completed during the measurement year as evidenced by one of the following:

- Both of the following during the same visit where the provider type is a prescribing practitioner or clinical pharmacist:
    - At least one medication review.
    - The presence of a medication list in the medical record.
- Transitional care management services.
- A medication list, signed and dated during the measurement year by the appropriate practitioner type (prescribing practitioner or clinical pharmacist)
- Documentation within the same medical record including:
    - A medication list in the medical record and evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed.
    - Notation that the member is not taking any medication and the date when it was noted.

Additional numerator exclusions:

- Medication lists or medication reviews performed in an acute inpatient setting.

NOTE: A review of side effects for a single medication at the time of prescription alone is not sufficient. An outpatient visit is not required to meet criteria.

NOTE: A medication review performed without the member present meets criteria.

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

COL-E: Colorectal Cancer Screening

CareAdvantage
Incentive-eligible

Source: NCQA HEDIS MY2026 metric of the same name.

Type: Percentage

Aim: Higher percentage indicates quality performance.

Application: Benchmark credit will be applied for this metric. HPSM's network rates will be reported back to providers.

Definition: The percentage of assigned HPSM CareAdvantage members 45–75 years of age who had appropriate screening for colorectal cancer.

Denominator: Assigned HPSM CareAdvantage members 45–75 years of age.

Exclusions:

- Members who have had colorectal cancer any time during the member's history through December 31 of the measurement year.
- Members who had a total colectomy any time during the member's history through December 31 of the measurement period.
- Members 66 years of age and older as of December 31 of the measurement year who are enrolled in an Institutional Special Needs Plan (I-SNP) or living long-term in an institution at any time during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year with frailty AND advanced illness.
- Members receiving palliative care or who had an encounter for palliative care any time during the measurement year.
- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement period.

Numerator: Members meeting denominator inclusion criteria with appropriate screening for colorectal cancer documented. Any of the following meet criteria:

- Fecal occult blood test (FOBT) during the measurement period.
- Stool DNA (sDNA) with FIT test during the measurement period or the 2 years prior to the measurement period.
- Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period.
- CT colonography during the measurement period or the 4 years prior to the measurement period.
- Colonoscopy during the measurement period or the 9 years prior to the measurement period.

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

Code	Definition	Code System
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
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
74261	CT Colonography	CPT

Code	Definition	Code System
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 Older Adults

CareAdvantage
Reporting-only

Source: NCQA HEDIS MY2026 metric of the same name.

Type: Percentage.

Aim: Lower percentage indicates quality performance.

Definition: The percentage of assigned HPSM CareAdvantage members 67 years of age and older who had at least two dispensing events for the same high-risk medication.

Denominator: Assigned HPSM CareAdvantage members 67 years of age and older.

Exclusions:

- Members receiving palliative care or who had an encounter for palliative care any time during the measurement year.
- Members who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Members who die any time during the measurement period.

Numerator: Members meeting denominator inclusion criteria who received at least two dispensing events any days' supply) for high-risk medications from the same drug class on the same or different dates of service during the measurement year.

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

DSF-E-1: Depression Screening (12 years and older)

CareAdvantage
Incentive-eligible

Source: HPSM internal metric, modified from the NCQA HEDIS MY2026 metric of the same name.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM CareAdvantage members 12 years of age and older with an outpatient visit who were screened for clinical depression.

Denominator: Assigned HPSM CareAdvantage members 12 years of age and older (i.e., members who will turn 13 years of age after December 31st of the measurement year) who had an outpatient visit during the measurement period.

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.

Additional exclusions:

- Members who have a documented active diagnosis of depression or bipolar disorder.

Numerator: Members meeting denominator inclusion criteria for whom HPSM received sufficient document of a completed screening for clinical depression and, if screened positive, follow-up care.

- Screening tool may be a standardized instrument or 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.

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

DSF-E-2: Follow-up After a Positive Depression Screen (12 years and older)

CareAdvantage
Reporting-only

Source: HPSM internal metric, modified from the NCQA HEDIS MY2026 metric of the same name.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members 12 years of age and older with an outpatient visit who were screened for clinical depression and, if screened positive, received follow-up care.

Denominator: Assigned HPSM CareAdvantage members 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.

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.

Additional exclusions:

- Members who have a documented active diagnosis of depression or bipolar disorder.

Numerator: Members meeting denominator inclusion criteria for whom HPSM received sufficient document of a completed screening for clinical depression and, if screened positive, follow-up care.

- Screening tool may be a standardized instrument or 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 same date as a positive screen.

EED: Eye Exam for Patients with Diabetes

CareAdvantage
Incentive-eligible

Source: NCQA HEDIS MY2026 metric of the same name.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM CareAdvantage members with a diagnosis of diabetes (types 1 and 2) with sufficient documentation of screening or monitoring for diabetic retinal disease as identified by administrative data.

Denominator: Assigned HPSM CareAdvantage members 18 -75 years of age with a diagnosis of diabetes (type 1 or 2) as identified by claim/encounter data and/or pharmacy data. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

- Claim/encounter data: Members who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year.
- Pharmacy data: Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.

Additional exclusions:

- Bilateral absence of eyes any time during the member's history through December 31 of the measurement year.
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year:
    - Unilateral eye enucleation with a bilateral modifier (CPT Modifier code 50).
    - Two unilateral eye enucleations with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15.
    - Left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) and right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) on the same or different dates of service.
    - A unilateral eye enucleation and a left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) with service dates 14 days or more apart.
    - A unilateral eye enucleation and a right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) with service dates 14 days or more apart.

NOTE: Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.

Numerator: Members meeting denominator inclusion criteria for whom there is sufficient documentation of screening or monitoring for diabetic retinal disease via administrative data.

- This includes people with diabetes who had one of the following:
    - A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
    - A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
- Any of the following meet criteria:
    - Retinal eye exam billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
    - Retinal eye exam billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications.
    - Eye exam with evidence of retinopathy billed by any provider type during the measurement year.
    - Eye exam without evidence of retinopathy billed by any provider type during the year prior to the measurement year.
    - Retinal imaging with interpretation and reporting by a qualified reading center billed by any provider type during the measurement year.
    - Automated Autonomous eye exam (CPT code 92229) billed by any provider type during the measurement year.
    - Diabetic retinal screening negative in prior year (CPT-CAT-II code 3072F) billed by any provider type during the measurement year.
    - Any combination that indicates findings from a retinal exam for diabetic retinopathy performed in both the left and right eye by any provider, or a combination that indicates one eye is enucleated and the other was examined.

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

Code	Definition	Code System
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

Code	Definition	Code System
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
2025F	Diabetic Retinal Screening With Eye Care Professional	CPT II
2026F	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

Code	Definition	Code System
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

FLU: Seasonal Influenza Vaccination

CareAdvantage
Incentive-eligible

Source: HPSM internal metric.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM CareAdvantage members 19 years of age and older receiving a seasonal flu vaccination July 1, 2026 through March 31, 2026.

Denominator: Assigned HPSM CareAdvantage members 19 years of age 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**

Additional exclusions:

- Diagnosis of pregnancy during the measurement period.

Numerator: Members meeting denominator inclusion criteria for whom HPSM received sufficient documentation a flu vaccine was administered between July of the measurement year through March of the following calendar year *OR* evidence of flu vaccine from the California Immunization Registry (CAIR) administered July of the measurement year through March of the following calendar year.

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

Code	Definition	Code System
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

Code	Definition	Code System
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

GSD-2: Glycemic Status Assessment for Patients with Diabetes: >9.0%

CareAdvantage
Incentive-eligible

Source: Rate 2 of the NCQA HEDIS MY2026 metric GSD.

Type: Percentage.

Aim: Lower percentage indicates quality performance.

Definition: The percentage of assigned HPSM CareAdvantage members 18–75 years of age with a diagnosis of diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was >9.0% during the measurement year as identified by automated laboratory data or administrative data.

Denominator: Assigned HPSM CareAdvantage members 18 -75 years old with a diagnosis of diabetes (types 1 or 2) as identified by claim/encounter data and/or pharmacy data. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

- Claim/encounter data: Members who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year.
- Pharmacy data: Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.

Numerator: Members meeting denominator inclusion criteria for whom the most recent glycemic status assessment (HbA1c or GMI) received by HPSM during the measurement year was >9.0% as identified by automated laboratory or administrative data.Diabetes Glycemic Status 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.

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 may not be 100% complete. It is important to check your monthly reports and follow up with the lab provider to obtain results for your patients.

HPC: Hospitalization for Potentially Preventable Complications

CareAdvantage
Reporting-only

Source: Modified presentation of the NCQA HEDIS MY2026 metric of the same name.

Type: Percentage

Aim: Lower percentage indicates quality performance.

Application: Neither full nor partial credit benchmarks will be applied for this metric. HPSM's network rates will be reported back to providers.

Definition: The percentage of assigned HPSM CareAdvantage members 67 years of age or older discharged from an acute inpatient or observation stay for an ambulatory care sensitive condition (ACSC).

Denominator: Assigned HPSM CareAdvantage members 67 years of age and older.

Exclusions:

- Members enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year.
- Members living long-term in an institution any time during the measurement year.
- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.

Numerator: Members meeting denominator inclusion criteria who were discharged from an acute inpatient or observation stay for which the principle diagnosis was an ambulatory care sensitive condition (ACSC).

- For discharges with one or more direct transfers, the last discharge is used.

Additional numerator exclusions:

- Nonacute inpatient stays.

List of Ambulatory Care Sensitive Conditions (ACSC)

Ambulatory care sensitive conditions (ACSC) are 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.
    - Severe pressure ulcers.

PCR: Plan All-Cause Readmissions

CareAdvantage
Reporting-only

Source: NCQA HEDIS MY2026 metric of the same name.

Type: Percentage.

Aim: Lower percentage indicates quality performance.

Definition: The percentage of assigned HPSM CareAdvantage members 18 years of age and older with an acute inpatient or observation stays during the measurement year followed by an unplanned acute readmission for any diagnosis within 30 days.

Denominator: HPSM CareAdvantage members 18 years of age and older with an acute inpatient or observation stay discharges on or between January 1 and December 1 of the measurement year.

- Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are 2 or more calendar days apart are considered distinct stays.
- Includes acute discharges from any type of facility (including behavioral healthcare facilities).
- For discharges with one or more direct transfers, the last discharge date is used.

Additional exclusions:

- Nonacute inpatient stays
- Hospital stays where the admission date is the same as the discharge date.
- Hospital stays meeting the following criteria:
    - Member died during the stay.
    - Members with a principal diagnosis of pregnancy on the discharge claim.
    - A principal diagnosis of a condition originating in the perinatal period on the discharge claim.

Numerator: Members meeting denominator inclusion criteria for whom the acute inpatient or observation stay was followed by an unplanned acute readmission for any diagnosis within 30 days.

- Readmissions include acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement year.

Additional numerator exclusions:

- Acute hospitalizations with any of the following criteria on the discharge claim:
- A principal diagnosis of pregnancy

- A principal diagnosis for a condition originating in the perinatal period
- A planned hospital stay 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.

SBIRT: Substance Misuse Screening and Follow Up

CareAdvantage
Reporting-only

Source: HPSM internal metric.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

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

Denominator: Assigned HPSM CareAdvantage members 12 years of age and older.

Numerator: Members meeting denominator inclusion criteria for whom HPSM received one of the following procedure codes within the measurement period.

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

CareAdvantage
Reporting-only

Source: HPSM internal metric, in compliance with All Plan Letter 21-009.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Background: HPSM understands that medical care and healthcare services are one of many complex factors that influences members' health status. To create more holistic member profiles that consider other non-medical and environmental indicators of health, HPSM requests that providers assist in 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).

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

Denominator: All assigned HPSM CareAdvantage members.

Numerator: Members meeting denominator inclusion criteria for whom HPSM received one of the following procedure codes within the measurement period.

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

Z-Code	Description
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

Z-Code	Description
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-MR: Transitions of Care - Medication Reconciliation Post-Discharge

CareAdvantage
Incentive-eligible

Source: Rate 4 of NCQA HEDIS MY2026 metric TRC.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of discharges for assigned HPSM CareAdvantage 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).

Denominator: Acute or nonacute inpatient discharges for assigned HPSM CareAdvantage members 18 years of age and older on or between January 1 and December 1 of the measurement year.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

NOTE: The denominator for this measure is based on discharges, not members. If members had more than one discharge in the measurement year, all discharges on or between January 1 and December 1 are included.

Numerator: Members meeting denominator inclusion criteria for whom HPSM receives sufficient documentation of medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge (31 total days).

- Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meet criteria:
    - Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.
    - Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
    - Documentation of the member's current medications with a notation that the discharge medications were reviewed.
    - Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.

- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge.
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
- Notation that no medications were prescribed or ordered upon discharge.

NOTE: The following notations or examples of documentation do not count as numerator compliant:

- *Notification of Inpatient Admission and Receipt of Discharge Information:*
  - *Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission or discharge.*
  - *Documentation of notification that does not include a time frame or date when the documentation was received.*
- *Medication Reconciliation Post-Discharge:*
  - *The following examples (without a reference to "hospitalization," "admission" or "inpatient stay") are not considered evidence that the provider was aware of the member's hospitalization or discharge:*
    - *Documentation of "post-op/surgery follow-up."*
    - *Documentation only of a procedure that is typically inpatient (e.g. open-heart surgery).*
    - *Documentation indicating that the visit was with the same provider who admitted the member or who performed the surgery.*

NOTE: A medication reconciliation performed without the member present meets criteria.

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

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

CareAdvantage
Reporting-only

Source: Rate 3 of NCQA HEDIS MY2026 metric TRC.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of discharges for assigned HPSM CareAdvantage 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.

Denominator: Acute or nonacute inpatient discharges for assigned HPSM CareAdvantage members 18 years of age and older on or between January 1 and December 1 of the measurement year.

Exclusions:

- Members who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who die any time during the measurement year.

NOTE: The denominator for this measure is based on discharges, not members. If members had more than one discharge in the measurement year, all discharges on or between January 1 and December 1 are included.

Numerator: Members meeting denominator inclusion criteria for whom HPSM received sufficient documentation in the outpatient medical record including evidence of patient engagement within 30 days after discharge. Any of the following meet criteria:

- An outpatient visit, including office visits and home visits.
- A telephone visit.
- A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication.
- An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not in real-time, occurred between the member and provider).

NOTE: If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria.

Additional numerator exclusions:

- Patient engagement that occurs on the date of discharge.

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

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

IV . Health Education Resources

Some patients may benefit from additional support or information regarding health education or lifestyle changes 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 online Health Education Guide offers a wide variety of 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 may call HPSM's Health Education line at **650-616-2165**.

If you need additional health education resources to support the care you provide to our members, please send 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 Benchmark P4P, as well as acceptance of performance bonus payments, does not in any way modify or supersede terms or conditions of any agreement between HPSM and participating providers. There is no guarantee of future funding or incentive under any HPSM P4P performance bonus program. HPSM Benchmark P4P 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 incentive, 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 Benchmark P4P.

Any monies paid under Benchmark P4P 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 incentives.

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