Benchmark Pay-for-Performance Incentive

Medi-Cal Guidelines

2026 Measurement Year - Final 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.

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

Measures with 'NCQA HEDIS' listed as the 'Metric Source' align with the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Measurement Year 2025 (MY2025) Technical Specifications for Health Plans. The associated code lists provided herein may detail only a subset of the qualifying codes for metric inclusion and exclusion.

Adult Track Incentive-eligible Quality Metric Set

New

1. **Colorectal Cancer Screening (COL-E)** is now an incentive-eligible quality metric to align with NCQA HEDIS.

Changed

1. **Screening for Depression and Follow-Up Plan (CDF)** maintained as per HPSM design aligned with state standards. To support providers with the transition to DSF-E-DS, HPSM will use the best performance between CDF and DSF-E-DS for calculating the MY2026 Benchmark P4P composite quality score.
2. **Depression Screening and Follow-up (12 years and older) (DSF-E)** added to align with NCQA HEDIS. DSF-E has been separated to reflect the two associated actions of depression screening (DSF-E-DS) and follow-up for a positive screen (DSF-E-FU). Depression Screening (DSF-E-DS) is incentive-eligible and requires submission of the depression screening instrument name and associated score to HPSM, typically via supplemental data. To support providers with the transition to DSF-E-DS, HPSM will use the best performance between CDF and DSF-E-DS for calculating the MY2026 Benchmark P4P composite quality score.

Removed

1. **Substance Misuse Screening (SBIRT)** changed to reporting-only.

Adult Track Reporting-only Quality Metric Set

New

1. **Advance Care Planning (ACP)** added as reporting-only quality metric.
2. **Hospitalization for Potentially Preventable Complications (HPC)** added as reporting-only quality metric.
3. **Kidney Health Evaluation for Patients with Diabetes (KED)** added as reporting-only quality metric.
4. **Transitions of Care-Medication Reconciliation Post Discharge (TRC-MR)** added as reporting-only quality metric.
5. **Transitions of Care-Patient Engagement After Inpatient Discharge (TRC-PE)** added as reporting-only quality metric.

Changed

6. **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-FU) isa reporting-only metric.

Family Practice Incentive-eligible Quality Metric Set

New

1. **Colorectal Cancer Screening (COL-E)** is now an incentive-eligible quality metric to align with NCQA HEDIS.

Changed

1. **Screening for Depression and Follow-Up Plan (CDF)** maintained as per HPSM design aligned with state standards. To support providers with the transition to DSF-E-DS, HPSM will use the best performance between CDF and DSF-E-DS for calculating the MY2026 Benchmark P4P composite quality score.
2. **Depression Screening and Follow-up (12 years and older) (DSF-E)** added to align with NCQA HEDIS. DSF-E has been separated to reflect the two associated actions of depression screening (DSF-E-DS) and follow-up for a positive screen (DSF-E-FU). Depression Screening (DSF-E-DS) is incentive-eligible and requires submission of the depression screening instrument name and associated score to HPSM, typically via supplemental data. To support providers with the transition to DSF-E-DS, HPSM will use the best performance between CDF and DSF-E-DS for calculating the MY2026 Benchmark P4P composite quality score.

Removed

1. **Eye Exam for Patients with Diabetes (EED)** changed to reporting-only.

Family Practice Reporting-only Quality Metric Set

New

1. **Advance Care Planning (ACP)** added as reporting-only quality metric.
2. **Hospitalization for Potentially Preventable Complications (HPC)** added as reporting-only quality metric.
3. **Lead Screening in Children (LSC)** added as reporting-only quality metric.
4. **Kidney Health Evaluation for Patients with Diabetes (KED)** added as reporting-only quality metric.
5. **Transitions of Care-Medication Reconciliation Post Discharge (TRC-MR)** added as reporting-only quality metric.
6. **Transitions of Care-Patient Engagement After Inpatient Discharge (TRC-PE)** added as reporting-only quality metric.

Changed

7. **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-FU) is a reporting-only metric.

Pediatric Incentive-eligible Quality Metric Set

New

1. **Lead Screening in Children (LSC)** is now an incentive-eligible quality metric.
2. **Well Child Visit (15-30 months old) (W30_2)** is now an incentive-eligible quality metric.

Changed

1. **Screening for Depression and Follow-Up Plan (CDF)** maintained as per HPSM design aligned with state standards. To support providers with the transition to DSF-E-DS, HPSM will use the best performance between CDF and DSF-E-DS for calculating the MY2026 Benchmark P4P composite quality score.
2. **Depression Screening and Follow-up (12 years and older) (DSF-E)** added to align with NCQA HEDIS. DSF-E has been separated to reflect the two associated actions of depression screening (DSF-E-DS) and follow-up for a positive screen (DSF-E-FU). Depression Screening (DSF-E-DS) is incentive-eligible and requires submission of the depression screening instrument name and associated score to HPSM, typically via supplemental data. To support providers with the transition to DSF-E-DS, HPSM will use the best performance between CDF and DSF-E-DS for calculating the MY2026 Benchmark P4P composite quality score.

Removed

1. **Weight Assessment & Nutrition Counseling for Children (WCC-N)** changed to reporting-only.
2. **Physical Activity Counseling for Children (WCC_PA)** changed to reporting-only.

Pediatric 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-FU) is a reporting-only metric.

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I. Overview

Health Plan of San Mateo's (HPSM) Benchmark Pay-for-Performance Incentive ("Benchmark P4P" or "incentive") shares data with in-network Medi-Cal 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 Medi-Cal primary care contract with HPSM for the entire duration between January 1, 2026 and June 30, 2027;
2. Clinic and/or associated medical group must have a minimum of 100 HPSM Medi-Cal 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 enrolled in the Care Gap Pay-for-Performance Incentive ("Care Gap P4P"), administered by Stellar Health. Providers enrolled in Care Gap P4P are eligible for HPSM's Earnings Guarantees; see Care Gap P4P Guidelines for details.
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.

Program Tracks

Medi-Cal providers are assigned one of three Benchmark P4P sub-tracks based on the approximate age range of members assigned to their clinic and/or associated medical group:

- **Adult**: Assigned members 18 years and older (no maximum)
- **Family Practice**: Assigned members 0 years and older (no maximum)
- **Pediatrics**: Assigned members 0 – 18 years or similar age range

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 adjust 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 quality for inclusion per 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 Program Year are published **at the beginning of each month between May 2026 and April 2027.** The website for eReports login is: https://reports.hpsm.org. Additional resources, including an eReports User Guide and select 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.
Monthly eReports Available	05/01/2026 – 04/30/2027	Monthly metric performance and associated member-level reports available via HPSM eReports portal. All providers may access; contact PSInquiries@hpsm.org for new account set up. As applicable, eReports' metric numerator and denominator inclusion/exclusion criteria align with NCQA HEDIS MY2025 Technical Specifications for Health Plans.
Supplemental Data Submission Deadline	03/26/2027*	All supplemental data (e.g., EMR extracts, lab submissions) must be submitted by this date to ensure inclusion for incentive calculation.
Claims Submission Deadline	03/26/2027	All HPSM claims and qualifying codes must be submitted by this date to ensure inclusion for incentive calculation.
Attestation Period	04/01/2027 – 04/30/2027	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 for Providers Solely Participating in Benchmark P4P	Quarter 3 2027 (July-September)	HPSM compiles performance data and calculates incentive earnings 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.
Earnings Guarantee Calculations for Providers Participating in Care Gap P4P	Quarter 4 2027 (October-December)	HPSM compiles performance data and calculates incentive earnings as explained in the 'Incentive Bonus Calculation Formula' section. Earnings are compared to that of Care Gap Pay-for-Performance (Care Gap P4P) and, as applicable, Benchmark P4P Earnings Guarantees are distributed; see Care Gap P4P Guidelines for details. 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, 2026 is the cut-off date for files being received by HSPM for the first time.

Incentive Bonus Calculation Formula

Final Benchmark P4P incentive earnings are 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 Medi-Cal 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 fifteen (15) eligible patients in the denominator. If fewer than fifteen eligible patients are 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 are 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. Adult Track Quality Metric Summary

Medi-Cal primary care clinics with an assigned panel of HPSM members 18 years of age and older (or a similar age range) report on the Adult Track quality metric set.

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

Adult Track 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	63%	60%
BPD	Blood Pressure Control for Patients with Diabetes	NCQA HEDIS	66%	54%
CBP	Controlling High Blood Pressure	NCQA HEDIS	69%	62%
CCS-E	Cervical Cancer Screening	NCQA HEDIS	61%	57%
CDF**	Screening for Depression and Follow-Up Plan	HPSM	48%	31%
COL	Colorectal Cancer Screening	NCQA HEDIS	50%	45%
DSF-E-DS**	Depression Screening (12 years and older)	HPSM	25%	17%
EED	Eye Exam for Patients with Diabetes	NCQA HEDIS	59%	56%
FLU	Seasonal Influenza Vaccine	HPSM	68%	57%
GSD-2*	Glycemic Status Assessment for Patients with Diabetes: >9.0%	NCQA HEDIS	25%	33%
IHA	Initial Health Appointment	HPSM	63%	50%

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

***To support providers with the transition to DSF-E-DS, which requires supplemental data submission, HPSM will use the best performance between CDF and DSF-E-DS for calculating the MY2026 Benchmark P4P composite quality score.*

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

Adult 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
ACE	Trauma Screening (Adverse Childhood Experiences)	HPSM
Avoid-ED*	Avoidable Emergency Department Visits	HPSM
CHA	Cognitive Health Assessment	HPSM
CHL	Chlamydia Screening in Women (16-24 years old)	HEDIS
DSF-E-FU	Follow-up After a Positive Depression Screen (12 years and older)	HPSM
GSD-1	Glycemic Status Assessment for Patients with Diabetes: <8.0%	HEDIS
HPC*	Hospitalization for Potentially Preventable Complications	NCQA HEDIS
KED	Kidney Health Evaluation for Patients with Diabetes	HEDIS
PCR*	Plan All-Cause Readmissions	HEDIS
SBIRT	Substance Misuse Screening	HPSM
SDoH	Z-Coding for Social Determinants of Health	HPSM
TBC	Tobacco Use Screening and Cessation Intervention (12 years and older)	HPSM
TRC-MR	Transitions of Care – Medications Reconciliation Post-Discharge	NCQA HEDIS
TRC-PE	Transitions of Care – Patient Engagement Post-Discharge	NCQA HEDIS

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

III. Family Practice Track Quality Metric Summary

Medi-Cal primary care providers with an assigned panel of HPSM members 0 - 999 years of age (no maximum) or a similar age range report on the Family Practice quality metric set.

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

Family Practice 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[ii]
BCS-E	Breast Cancer Screening	NCQA HEDIS	63%	60%
CBP	Controlling High Blood Pressure	NCQA HEDIS	69%	62%
CCS-E	Cervical Cancer Screening	NCQA HEDIS	61%	58%
CDF**	Screening for Depression and Follow-Up Plan	HPSM	61%	48%
COL	Colorectal Cancer Screening	NCQA HEDIS	50%	45%
DSF-E-DS**	Depression Screening (12 years and older)	HPSM	26%	15%
FLU	Seasonal Influenza Vaccine	HPSM	68%	57%
GSD-2*	Glycemic Status Assessment for Patients with Diabetes: >9.0%	NCQA HEDIS	28%	33%
IHA	Initial Health Appointment	NCQA HEDIS	73%	64%
W30-6	Well Child Visit (0-15 months old)	NCQA HEDIS	70%	65%
WCV	Well Child and Adolescent Visit (3 – 21 years old)	NCQA HEDIS	65%	58%

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

***To support providers with the transition to DSF-E-DS, which requires supplemental data submission, HPSM will use the best performance between CDF and DSF-E-DS for calculating the MY2026 Benchmark P4P composite quality score.*

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

Family Practice 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
ACE	Trauma Screening (Adverse Childhood Experiences)	HPSM
Avoid-ED*	Avoidable Emergency Department Visits	HPSM
BPD	Blood Pressure Control for Patients with Diabetes	NCQA HEDIS
CHA	Cognitive Health Assessment	HPSM
CHL	Chlamydia Screening in Women (16 – 24 years old)	NCQA HEDIS
CIS-10	Childhood Immunizations (Combination 10)	NCQA HEDIS
DEV	Developmental Screening	HPSM
DSF-E_2	Follow-up After a Positive Depression Screen (12 years and older)	HPSM
EED	Eye Exam for Patients with Diabetes	NCQA HEDIS
FVN	Fluoride Varnish	HPSM
GSD-1	Glycemic Status Assessment for Patients with Diabetes: <8.0%	NCQA HEDIS
HPC*	Hospitalization for Potentially Preventable Complications	NCQA HEDIS
IMA-2	Immunizations for Adolescent (Combination 2)	NCQA HEDIS
KED	Kidney Health Evaluation for Patients with Diabetes	NCQA HEDIS
PCR*	Plan All-Cause Readmissions	NCQA HEDIS

Shorthand	Reporting-Only Metric Name	Metric Source
SBIRT	Substance Misuse Screening and Follow Up (12 years and older)	HPSM
SDoH	Z-Coding for Social Determinants of Health	HPSM
TBC	Tobacco Use Screening and Cessation Intervention (12 years and older)	HPSM
TRC-MR	Transitions of Care – Medications Reconciliation Post-Discharge	NCQA HEDIS
TRC-PE	Transitions of Care – Patient Engagement Post-Discharge	NCQA HEDIS
W30-2	Well Child Visit (15-30 months)	NCQA HEDIS
WCC-BMI	Pediatric BMI Assessment	NCQA HEDIS
WCC-N	Nutrition Counseling for Children	NCQA HEDIS
WCC-PA	Physical Activity Counseling for Children	NCQA HEDIS

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

IV. Pediatric Track Quality Metric Summary

Medi-Cal primary care providers with an assigned panel of HPSM members 0 - 18 years of age (or similar ranges) report on the Pediatric quality metric set.

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

Pediatric 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 Metrics, earning 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[iii]
CDF**	Screening for Depression and Follow-Up Plan	HPSM	81%	75%
CIS-10	Childhood Immunizations (Combination 10)	NCQA HEDIS	64%	52%
DSF-E-DS**	Depression Screening (12 years and older)	HPSM	23%	11%
FLU	Seasonal Influenza Vaccine	HPSM	70%	60%
IMA-2	Immunizations for Adolescent (Combination 2)	NCQA HEDIS	68%	57%
LSC	Lead Screening in Children	NCQA HEDIS	80%	71%
SBIRT	Substance Misuse Screening	NCQA HEDIS	65%	53%
TBC	Tobacco Use Screening and Cessation Intervention (12 years and older)	HPSM	52%	36%
W30-2	Well Child Visit (15-30 months old)	NCQA HEDIS	80%	73%
W30-6	Well Child Visit (0-15 months old)	NCQA HEDIS	70%	65%
WCV	Well Child and Adolescent Visit (3-21 years old)	NCQA HEDIS	65%	58%

***To support providers with the transition to DSF-E-DS, which requires supplemental data submission, HPSM will use the best performance between CDF and DSF-E-DS for calculating the MY2026 Benchmark P4P composite quality score.*

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

Pediatric 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
ACE	Trauma Screening (Adverse Childhood Experiences)	HPSM
Avoid-ED*	Avoidable Emergency Department Visit	HPSM
CHL	Chlamydia Screening in Women (16-24 years old)	HEDIS
DEV	Developmental Screening	HPSM
DSF-E-FU	Follow-up After a Positive Depression Screen (12 years and older)	HPSM
FVN	Fluoride Varnish	HPSM
IHA	Initial Health Appointment	HPSM
SDoH	Z-Coding for Social Determinants of Health	HPSM
WCC-BMI	Pediatric BMI Assessment	HEDIS
WCC-N	Weight Assessment & Nutrition Counseling for Children	NCQA HEDIS
WCC-PA	Physical Activity Counseling for Children	NCQA HEDIS

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

V. Quality Metric Specifications

ACE: Adverse Childhood Experiences Trauma Screening

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Background: Eligible providers continue to receive directed payments of $29 per screening via Proposition 56 funds. To participate, providers must complete and attest to a free two-hour training on the science of ACEs and toxic stress. Providers may also earn Continuing Medical Education (CME) and Maintenance of Certification (MOC) credits through this training.

- For more information, please visit https://acesaware.org or email PSInquiries@hpsm.org.

Definition: Percentage of assigned HPSM Medi-Cal members under age 21 screened for ACEs using the *Pediatric ACEs and Related Life-events Screener (PEARLS)* tool during the measurement period.

Denominator: Assigned HPSM Medi-Cal members under age 21.

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

- Trauma Screening Healthcare Common Procedure Coding System (HCPCS) Codes:

Code	Definition	Code System
G9919	Trauma Screening: Positive screen with patient score of 4 or greater	HCPCS
G9920	Trauma Screening: Negative screen with patient score of 0 to 3	HCPCS

ACP: Advance Care Planning

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

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	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 Medi-Cal members 1 year of age and older.

Denominator: Assigned HPSM Medi-Cal members 1 year of age and older 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

Type: Percentage.

Aim: Higher percentage indicates quality performance.

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

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

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

BPD: Blood Pressure Control for Patients with Diabetes

Adult	Family Practice	Pediatrics
Incentive-eligible	Reporting-only	Not Included

Source: NCQA HEDIS metric of the same name.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members 18–75 years of age with diabetes (types 1 and 2) whose most recent blood pressure (BP) reading was adequately controlled (<140/90 mm Hg).

Denominator: Member 18-75 years old with diabetes (types 1 or 2) as identified by either:

- Claim/encounter data documenting 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 documenting the member was 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 (Diabetes Value Set) during the measurement year or the year prior to the measurement year.

Numerator: Members meeting denominator inclusion criteria for whom the most recent BP taken during the measurement period is <140/90 mm Hg, as documented through administrative data or medical record review. Must include both systolic and diastolic blood pressure results as documented through administrative data.

Diabetes Blood Pressure Procedure Codes

Code	Definition	Code System
3079F	DIAST BP 80-89 MM HG	CPTII
3080F	DIAST BP >/= 90 MM HG	CPTII
3078F	DIAST BP <80 MM HG	CPTII
3077F	SYST BP >/= 140 MM HG	CPTII
3074F	SYST BP LT 130 MM HG	CPTII
3075F	SYST BP GE 130 - 139MM HG	CPTII

CBP: Controlling High Blood Pressure

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Not Included

Source: NCQA HEDIS metric of the same name.

Type: Percentage

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal 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 period.

Denominator: Assigned HPSM Medi-Cal members 18-85 years old 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.

Additional 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
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

CCS-E: Cervical Cancer Screening

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Not Included

Source: NCQA HEDIS metric of the same name.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members 21–64 years of age recommended and screened for cervical cancer screening who were screened for cervical cancer.

Denominator: Assigned HPSM Medi-Cal members 21–64 years of age who were recommended for routine cervical cancer screening.

Additional exclusions:

- Members who have had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during their history through December 31, 2022 may be excluded (see "Cervical Cancer Exclusion Codes")

Cervical Cancer Screening Exclusion Codes

In order for patients to be excluded from the cervical cancer screening performance metric calculation HPSM must have documented evidence of a complete hysterectomy. For new patients, we do not always have this data. If you believe a patient is listed as eligible for this service in the P4P member detail report in error, then please submit one of the following diagnosis codes with the claim for the patient's next primary care visit:

Code	Definition	Code System
Q51.5	Agenesis and aplasia of cervix	ICD10CM
Z90.710	Acquired absence of both cervix and uterus	ICD10CM
Z90.712	Acquired absence of cervix with remaining uterus	ICD10CM
0UTC0ZZ	Resection of Cervix, Open Approach	ICD10PCS
0UTC4ZZ	Resection of Cervix, Percutaneous Endoscopic Approach	ICD10PCS
0UTC7ZZ	Resection of Cervix, Via Natural or Artificial Opening	ICD10PCS
0UTC8ZZ	Resection of Cervix, Via Natural or Artificial Opening Endoscopic	ICD10PCS

3015F	**Modifier 1P** Cervical cancer screening not performed for Medical Reasons	CPT II

Numerator: Members meeting denominator inclusion criteria for whom HPSM received sufficient documentation of cervical cancer screening within the measurement period per one of the following criteria:

- Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years (36 calendar months).
- Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years (72 calendar months).
- Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

Cervical Cancer Screening Procedure Codes

Code	Definition	Code System
88141	Cervical Cytology	CPT
88142	Cervical Cytology	CPT
88143	Cervical Cytology	CPT
88147	Cervical Cytology	CPT
88148	Cervical Cytology	CPT
88150	Cervical Cytology	CPT
88152	Cervical Cytology	CPT
88153	Cervical Cytology	CPT
88154	Cervical Cytology	CPT
88164	Cervical Cytology	CPT
88165	Cervical Cytology	CPT
88166	Cervical Cytology	CPT
88167	Cervical Cytology	CPT
88174	Cervical Cytology	CPT
88175	Cervical Cytology	CPT
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision (G0123)	HCPCS

Code	Definition	Code System
G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician (G0124)	HCPCS
G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician (G0141)	HCPCS
G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision (G0143)	HCPCS
G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision (G0144)	HCPCS
G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision (G0145)	HCPCS
G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision (G0147)	HCPCS
G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening (G0148)	HCPCS
P3000	Screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision (P3000)	HCPCS
P3001	Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician (P3001)	HCPCS
Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory (Q0091)	HCPCS
3015F	Cervical cancer screening results documented and reviewed	CPT II

HPV Testing Codes

Code	Definition	Code System
87620	HPV detection by DNA or RNA, direct probe technique	CPT
87621	HPV detection by DNA or RNA, amplified probe technique	CPT
87622	HPV quantification	CPT
87624	Human Papillomavirus (HPV), high-risk types	CPT
87625	Human Papillomavirus (HPV)	CPT
G0476	Infectious agent detection by nucleic acid (DNA or RNA); human papillomavirus (HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test (G0476)	HCPCS

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

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Incentive-eligible

Metric Source: HPSM internal metric.

Patient Eligibility: 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.

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

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

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

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

Depression Screening Procedure Codes

Code	Definition	Code System
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

CHA: Cognitive Health Assessment

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Not Included

Source: HPSM internal metric, in compliance with the California Department of Health Care Services (DHCS) All Plan Letter (APL) 22-025.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members 65 and older who received an eligible cognitive health assessment in the measurement year.

In order to receive reimbursement for administering cognitive health assessments to Medi-Cal members not also receiving Medicare benefits, providers must complete and submit attestation of completion via Dementia Care Aware, a state-wide provider education and training program administered by the University of California, San Francisco. Visit dementiacareaware.org or email PSInquiries@hpsm.org for more information.

Denominator: Assigned HPSM Medi-Cal members 65 years of age and older.

Numerator: Members meeting denominator inclusion criteria for whom HPSM received sufficient documentation confirming an eligible cognitive health assessment was completed within the measurement period. Eligible Cognitive assessment tools used to determine if a full dementia evaluation is needed include, but are not limited to:

- Patient assessment tools
    - General Practitioner assessment of Cognition (GPCOG)
    - Mini-Cog
- Informant tools (family members and close friends)
    - Eight-item Informant Interview to Differentiate Aging and Dementia
    - GPCOG
    - Short Informant Questionnaire on Cognitive Decline in the Elderly

Cognitive Health Assessment Procedure Codes

Code	Definition	Code System
96116	Neuropsychological testing	CPT
96136	Neuropsychological testing	CPT
96138	Neuropsychological testing	CPT
96146	Neuropsychological testing	CPT
99483	Neuropsychological testing	CPT
71492-3	Total Score, Saint Louis University Mental Status examination (SLUMS)	LOINC
71947-6	Saint Louis University Mental Status examination (SLUMS)	LOINC
72088-8	Clinical Dementia Rating (CDR)	LOINC
72106-8	Total Score, Mini-Mental State Examination (MMSE)	LOINC
72107-6	Mini-Mental State Examination (MMSE)	LOINC
72133-2	Montreal Cognitive Assessment [MoCA]	LOINC
72172-0	Total Score, Montreal Cognitive Assessment [MoCA]	LOINC
72233-0	Total Score, Mini-cog	LOINC
72234-8	Mini-cog	LOINC

CHL: Chlamydia Screening in Women (16-24 years old)

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

Source: NCQA HEDIS metric of the same name.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members 16–24 years of age who were recommended for routine chlamydia screening, were identified as sexually active and had at least one test for chlamydia during the measurement year.

Denominator: Assigned HPSM Medi-Cal members 16–24 years of age identified as sexually active and recommended for routine chlamydia screening.

Additional exclusions:

- Members for whom the assigned sex at birth was male.

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

Chlamydia Testing Codes

Code	Definition	Code System
87110	Chlamydia Test	CPT
87270	Chlamydia Test	CPT
87320	Chlamydia Test	CPT
87490	Chlamydia Test	CPT
87491	Chlamydia Test	CPT
87492	Chlamydia Test	CPT
87810	Chlamydia Test	CPT

CIS-10: Immunizations for Children – Combo 10

Adult	Family Practice	Pediatrics
Not included	Reporting-Only	Incentive-eligible

Source: Combination 10 of the NCQA HEDIS metric CIS-E.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Denominator: Assigned HPSM Medi-Cal members who turn 2 years of age during the measurement period.

Additional exclusions:

- Members who had a contraindication to an included vaccine on or before their second birthday.
- Members who had an organ or bone marrow transplant on or before their second birthday.

Numerator: Members meeting denominator inclusion criteria for whom HPSM received documentation of sufficient compliance for each of the following criteria on or before the child's second birthday:

- Diphtheria, tetanus and acellular pertussis (DTaP)
    - At least four DTaP vaccinations, with different dates of service on or after 42 days after birth.
    - Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine.
    - Encephalitis due to the diphtheria, tetanus or pertussis vaccine.
- Polio (IPV)
    - At least three IPV vaccinations with different dates of service on or after 42 days after birth.
    - Anaphylaxis due to the IPV vaccine.
- Measles, mumps and rubella (MMR)
    - At least one MMR vaccination on or between the child's first and second birthdays.
    - All of the following any time on or before the child's second birthday:
        - History of measles illness.
        - History of mumps illness.
        - History of rubella illness.

    - Anaphylaxis due to the MMR vaccine.
- Haemophilus influenza type B (HiB)
    - At least three HiB vaccinations with different dates of service on or after 42 days after birth.
    - Anaphylaxis due to the HiB vaccine.
- Hepatitis B (HepB)
    - At least three hepatitis B vaccinations with different dates of service.
        - One of the three vaccinations may be a newborn hepatitis B vaccination (ICD-10-PCS code 3E0234Z) during the 8-day period that begins on the date of birth and ends 7 days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
    - History of hepatitis B illness.
    - Anaphylaxis due to the hepatitis B vaccine.
- Chicken pox (VZV)
    - At least one VZV vaccination with a date of service on or between the child's first and second birthdays.
    - History of varicella zoster (e.g., chicken pox) illness on or before the child's second birthday.
    - Anaphylaxis due to the VZV vaccine.
- Pneumococcal conjugate (PCV)
    - At least four pneumococcal conjugate vaccinations with different dates of service on or after 42 days after birth.
    - Anaphylaxis due to the pneumococcal vaccine.
- Hepatitis A (HepA)
    - At least one hepatitis A vaccination with a date of service on or between the child's first and second birthdays.
    - History of hepatitis A illness.
    - Anaphylaxis due to the hepatitis A vaccine.
- Rotavirus (RV)
    - At least two doses of the two-dose rotavirus vaccine on different dates of service on or after 42 days after birth.
    - At least three doses of the three-dose rotavirus vaccine on different dates of service on or after 42 days after birth.

- At least one dose of the two-dose rotavirus vaccine and at least two doses of the three-dose rotavirus vaccine all on different dates of service on or after 42 days after birth.
- Anaphylaxis due to the rotavirus vaccine.

- Influenza (flu)
  - At least two influenza vaccinations with different dates of service on or after 180 days after birth.
    - An influenza vaccination recommended for children 2 years and older (e.g., LAIV) administered on the child's second birthday meets criteria for one of the two required vaccinations.
  - Anaphylaxis due to the influenza vaccine.

CIS Procedure Codes

Code	Definition	Code System
90700	DTaP Vaccine Procedure	CPT
90721	DTaP Vaccine Procedure	CPT
90723	DTaP Vaccine Procedure	CPT
90633		CPT
90644	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90645	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90646	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90647	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90648	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90698	Haemophilus Influenzae Type B (HiB) Vaccine Procedure/DTaP Vaccine Procedure	CPT
90721	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90748	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
B15.0	Hepatitis A with hepatic coma	ICD10CM
B15.9	Hepatitis A without hepatic coma	ICD10CM
B16.0	Acute hepatitis B with delta-agent with hepatic coma	ICD10CM
B16.1	Acute hepatitis B with delta-agent without hepatic coma	ICD10CM
B16.2	Acute hepatitis B without delta-agent with hepatic coma	ICD10CM

Code	Definition	Code System
B16.9	Acute hepatitis B without delta-agent and without hepatic coma	ICD10CM
B17.0	Acute delta-(super) infection of hepatitis B carrier	ICD10CM
B18.0	Chronic viral hepatitis B with delta-agent	ICD10CM
B18.1	Chronic viral hepatitis B without delta-agent	ICD10CM
B19.10	Unspecified viral hepatitis B without hepatic coma	ICD10CM
B19.11	Unspecified viral hepatitis B with hepatic coma	ICD10CM
Z22.51	Carrier of viral hepatitis B	ICD10CM
08	hepatitis B vaccine, pediatric or pediatric/adolescent dosage	CVX
90723	Hepatitis B Vaccine Procedure	CPT
90740	Hepatitis B Vaccine Procedure	CPT
90744	Hepatitis B Vaccine Procedure	CPT
90747	Hepatitis B Vaccine Procedure	CPT
90748	Hepatitis B Vaccine Procedure	CPT
G0010	Administration of hepatitis b vaccine	HCPCS
3E0234Z	Introduction of Serum, Toxoid and Vaccine into Muscle, Percutaneous Approach	ICD10PCS
90670	Pneumococcal Conjugate Vaccine Procedure	CPT
G0009	Administration of pneumococcal vaccine	HCPCS
90681	Rotavirus Vaccine (2 Dose Schedule) Procedure	CPT
90680	Rotavirus Vaccine (3 Dose Schedule) Procedure	CPT
B06.00	Rubella with neurological complication, unspecified	ICD10CM
B06.01	Rubella encephalitis	ICD10CM
B06.02	Rubella meningitis	ICD10CM
B06.09	Other neurological complications of rubella	ICD10CM
B06.81	Rubella pneumonia	ICD10CM
B06.82	Rubella arthritis	ICD10CM
B06.89	Other rubella complications	ICD10CM
B06.9	Rubella without complication	ICD10CM
90706	Rubella Vaccine Procedure	CPT

COL-E: Colorectal Cancer Screening

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Not included

Source: NCQA HEDIS 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 Medi-Cal members 45–75 years of age who had appropriate screening for colorectal cancer.

Denominator: Assigned HPSM Medi-Cal 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
45335	Flexible Sigmoidoscopy	CPT

Code	Definition	Code System
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
74262	CT Colonography	CPT

Code	Definition	Code System
74263	CT Colonography	CPT
81528	CT Colonography	CPT
82270	FOBT Lab Test	CPT
82274	FOBT Lab Test	CPT

DEV: Developmental Screening

Adult	Family Practice	Pediatrics
Not included	Reporting-Only	Reporting-Only

Source: DHCS, under Proposition 56 directed payments in compliance with APL 23-016

Type: Percentage

Aim: Higher percentage indicates quality performance.

Background: Providers continue to receive directed payments via Proposition 56 funds. Providers receive $59.90 for each eligible developmental screening performed and reported using the Current Procedural Terminology (CPT) code 96110, without the KX modifier used to document screening for Autism Spectrum Disorder (ASD). **Note:** FQHCs are excluded from Prop 56 directed payments. For more information, please refer to the DHCS guidance at:

https://www.dhcs.ca.gov/provgovpart/Prop-56/Pages/Prop56-Screenings-Developmental.aspx

Definition: Percentage of assigned HPSM Medi-Cal members 30 months of age receiving developmental screening using standardized developmental screening tools during the periodic pediatric health visits that occur at 9 months, 18 months and 30 months.

Denominator: Assigned HPSM Medi-Cal members 30 months of age.

Additional exclusions:

- Members with more than one gap in enrollment of up to 45 days during the measurement year.

Numerator: Members meeting denominator inclusion criteria for whom HPSM received the CPT code 96110, without the KX modifier used to document screening for ASD, indicating developmental screenings, with scoring and documentation per a standardized instrument, were conducted during periodic health visits at 9 months, 18 months and 30 months per the following criteria:

- '9-month' developmental screening conducted on or before the first birthday.
- '18-month' developmental screening conducted after the first birthday and before or on the second birthday.
- '30-month' developmental screening after the second birthday and on or before the 30-month birthday.
- Providers must use a validated and age-appropriate standardized screening tool that meets the criteria set forth by the American Academy of Pediatrics (AAP) and the Centers for Medicare and Medicaid Services (CMS). The following tools currently meet the aforementioned criteria and are approved by DHCS:
    - Ages and Stages Questionnaire (ASQ) - 4 months to age 5
    - Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
    - Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months

    - Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
    - Brigance Screens-II - Birth to 90 months
    - Child Development Inventory (CDI) - 18 months to age 6
    - Infant Development Inventory - Birth to 18 months
    - Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
    - Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
- Providers must document and retain all of the following in the member's medical record:
    - Tool that was used
    - Completed screen was reviewed
    - Results of the screen
    - Interpretation of results
    - Discussion with the member and/or family
    - Any appropriate actions taken. This documentation
- CPT code 96110, without the KX modifier used to document screening for Autism Spectrum Disorder.
- Additional developmental screenings done when medically necessary due to risk identified on developmental surveillance are also eligible for directed payment if completed with standardized developmental screening tools and documented with CPT code 96110 without the modifier KX.

Developmental Screening Procedure Codes

Code	Definition	Code System
96110	Developmental screening with scoring and documentation, per standardized instrument	CPT

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

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Incentive-eligible

Source: HPSM internal metric, modified from the NCQA HEDIS 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.

Denominator: Assigned HPSM Medi-Cal 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.

- 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
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

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

Adult	Family Practice	Pediatrics
Reporting-only	Reporting-only	Reporting-only

Source: HPSM internal metric, modified from the NCQA HEDIS 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 Medi-Cal 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.

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

EED: Eye Exam for Patients with Diabetes

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Not Included

Source: NCQA HEDIS metric of the same name.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members 18–75 years of age 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 Medi-Cal members 18 -75 years of age 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.

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

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Incentive-eligible

Source: HPSM internal metric.

Type: Percentage

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members 6 months and older receiving a seasonal flu vaccination July 1, 2026 through March 31, 2026.

Denominator: Assigned HPSM Medi-Cal 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**

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 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
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

Code	Definition	Code System
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

FVN: Fluoride Varnish

Adult	Family Practice	Pediatrics
Not Included	Reporting-Only	Reporting-Only

Source: HPSM internal metric.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: Percentage of assigned HPSM Medi-Cal members ages 0-5 who received fluoride varnish at least two times during the measurement period.

Denominator: Assigned HPSM Medi-Cal members 0-5 years of age.

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

Fluoride Varnish Procedure Codes

Code	Definition	Code System
99188	Topical application of fluoride varnish	CPT
D1206	Topical application of fluoride varnish	HCPCS

GSD-1: Glycemic Status Assessment for Patients with Diabetes: <8.0%

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Not Included

Source: Rate 1 of the NCQA HEDIS metric GSD.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal 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 <8.0% during the measurement year as identified by automated laboratory data or administrative data.

Denominator: Assigned HPSM Medi-Cal 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 <8.0%.

- The member is not numerator compliant if the result of the most recent glycemic status assessment is ≥8.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year.
- If there are multiple glycemic status assessments on the same date of service, the lower result will be used.

Diabetes Glycemic Status Procedure Codes

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

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

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Not Included

Source: Rate 2 of the NCQA HEDIS metric GSD.

Type: Percentage.

Aim: Lower percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal 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 Medi-Cal 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%.

- The member is numerator compliant if the most recent glycemic status assessment has a result of >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year.
- The member is not numerator compliant if the result of the most recent glycemic status assessment during the measurement year is ≤9.0%.
- If there are multiple glycemic status assessments on the same date of service, the lower result will be used.

Diabetes Glycemic Status Procedure Codes

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

HPC: Hospitalization for Potentially Preventable Complications

Adult	Family Practice	Pediatrics
Reporting-only	Reporting-only	Not included

Source: Modified presentation of the NCQA HEDIS 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 Medi-Cal 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 Medi-Cal 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.

IHA: Initial Health Appointment

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Reporting-Only

Source: HPSM internal metric.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: Percent of newly enrolled and assigned HPSM Medi-Cal members who had an Initial Health Appointment (IHA) within 120 days of HPSM enrollment (generally within 90 days of panel assignment) or the submission of an IHA procedure code listed below in the 12 months prior to re-enrollment with HPSM. The Active Engagement report sent monthly through the HPSM eReports system can help conduct outreach to newly enrolled HPSM members who are newly assigned to your panel.

Denominator: Newly enrolled assigned HPSM Medi-Cal members (within 120 days of Health Plan enrollment AND 90 days of assignment to primary care panel).

Numerator: Members meeting denominator inclusion criteria for whom HPSM received one of the IHA Procedure Codes within the measurement period, per the requirements below:

A complete IHA must:

- Be completed by a provider within the primary care medical setting;
- Be performed in a way that is culturally and linguistically considerate;
- Be documented in a member's medical record;
- Include:
    - A history of the member's physical and mental health;
    - An identification of risks;
    - An assessment of need for preventive screens or services;
    - The diagnosis and plan for treatment of any diseases;
    - Any additional health education provided.

Providers may track outreach attempts to attest to members who receive at least three outreach attempts during the measurement year for partial P4P credit. Providers must document date and modality of outreach attempts and share copies of scripting or other outreach materials with HPSM.

IHA Procedure Codes

Code	Definition	Code System
99201	Office/Outpt E&M New Minor 10	CPT
99202	Office/Outpt E&M New Low-Mod	CPT
99203	Office/Outpt E&M New Mod Seve	CPT
99204	Office/Outpt E&M New Mod-Hi 4	CPT
99205	Office/Outpt E&M New Mod-Hi 6	CPT
99211	Office/Outpt E&M Estab 5 Min	CPT
99212	Office/Outpt E&M Estab Minor	CPT
99213	Office/Outpt E&M Estab Low-Mo	CPT
99214	Office/Outpt E&M Estab Mod-Hi	CPT
99215	Office/Outpt E&M Estab Mod-Hi	CPT
99241	Office Cons New/Estab Minor 1	CPT
99242	Office Cons New/Est Lo Sever	CPT
99243	Office Cons New/Estab Mod 40	CPT
99244	Office Cons New/Estab Mod-Hi	CPT
99245	Office Cons New/Estab Mod-Hi	CPT
99304	Nursing Facility Care Init	CPT
99305	Nursing Facility Care Init	CPT
99306	Nursing Facility Care Init	CPT
99307	Nursing Fac Care Subseq	CPT
99308	Nursing Fac Care Subseq	CPT
99309	Nursing Fac Care Subseq	CPT
99310	Nursing Fac Care Subseq	CPT
99315	Nurs Facil D/C Da Mgmt; 30 M	CPT
99316	Nurs Facil D/C Da Mgmt; > 30	CPT
99318	Annual Nursing Fac Assessmnt	CPT

Code	Definition	Code System
99324	Domicil/R-Home Visit New Pat	CPT
99325	Domicil/R-Home Visit New Pat	CPT
99326	Domicil/R-Home Visit New Pat	CPT
99327	Domicil/R-Home Visit New Pat	CPT
99328	Domicil/R-Home Visit New Pat	CPT
99334	Domicil/R-Home Visit Est Pat	CPT
99335	Domicil/R-Home Visit Est Pat	CPT
99336	Domicil/R-Home Visit Est Pat	CPT
99337	Domicil/R-Home Visit Est Pat	CPT
99341	Home Visit E&M New Pt Lo Sev	CPT
99342	Home Visit E&M New Pt Mod Se	CPT
99343	Home Visit E&M New Pt Mod-Hi	CPT
99344	Home Visit E&M New Pt Hi Sev	CPT
99345	Home Visit E&M New Pt Unstbl	CPT
99347	Home Visit E&M Estab Minor-1	CPT
99348	Home Visit E&M Estab Low-Mod	CPT
99349	Home Visit E&M Estab Mod-Hi	CPT
99350	Home Visit E&M Estab Mod-Hi	CPT
99354	Prolong Md Serv Outpt W/Pt;	CPT
99355	Prolong Md Serv Outpt W/Pt;	CPT
99381	Init Preven Meds E&M New Pt;	CPT
99382	Init Preven Meds E&M New Pt;	CPT
99383	Init Preven Meds E&M New Pt;	CPT
99384	Init Preven Meds E&M New Pt;	CPT
99385	Init Preven Meds E&M New Pt;	CPT
99386	Init Preven Meds E&M New Pt;	CPT

Code	Definition	Code System
99387	Init Preven Meds E&M New Pt;	CPT
99391	Preven Meds E&M Estab Pt; In	CPT
99392	Preven Meds E&M Estab Pt; 1-	CPT
99393	Preven Meds E&M Estab Pt; 5-	CPT
99394	Preven Meds E&M Estab Pt; 12	CPT
99395	Preven Meds E&M Estab Pt; 18	CPT
99396	Preven Meds E&M Estab Pt; 40	CPT
99397	Preven Meds E&M Estab Pt; 65	CPT
99401	Preven Med Counsl (Sep Pro);	CPT
99402	Preven Med Counsl (Sep Pro);	CPT
99403	Preven Med Counsl (Sep Pro);	CPT
99404	Preven Med Counsl (Sep Pro);	CPT
99411	Preven Med Counsl Grp (Sep P	CPT
99412	Preven Med Counsl Grp (Sep P	CPT
99420	Admin/Intrpt Health Risk Ass	CPT
99429	Unlisted Preven Meds Serv	CPT
99444	Online E/M By Phys	CPT
99446	Interprof Phone/Online 5-10	CPT
99447	Interprof Phone/Online 11-2	CPT
99448	Interprof Phone/Online 21-3	CPT
99449	Interprof Phone/Online 31/>	CPT
99450	Basic Life &/Or Disability E	CPT
99455	Work Relat/Disabl Exam-Treat	CPT
99456	Work Relat/Disabl Exam-Not T	CPT
G0402	Initial Preventive Exam	HCPCS
G0438	Ppps Initial Visit	HCPCS

Code	Definition	Code System
G0439	Ppps Subseq Visit	HCPCS
G0463	Hospital Outpt Clinic Visit	HCPCS
T1015	Clinic Service	HCPCS

IHA Diagnosis Codes

Code	Definition	Code System
Z00.00	Encounter for general adult medical examination without abnormal findings	ICD10CM
Z00.01	Encounter for general adult medical examination with abnormal findings	ICD10CM
Z00.121	Encounter for routine child health examination with abnormal findings	ICD10CM
Z00.129	Encounter for routine child health examination without abnormal findings	ICD10CM
Z00.5	Encounter for examination of potential donor of organ and tissue	ICD10CM
Z00.8	Encounter for other general examination	ICD10CM
Z02.0	Encounter for examination for admission to educational institution	ICD10CM
Z02.1	Encounter for pre-employment examination	ICD10CM
Z02.2	Encounter for examination for admission to residential institution	ICD10CM
Z02.3	Encounter for examination for recruitment to armed forces	ICD10CM
Z02.4	Encounter for examination for driving license	ICD10CM
Z02.5	Encounter for examination for participation in sport	ICD10CM
Z02.6	Encounter for examination for insurance purposes	ICD10CM

Code	Definition	Code System
Z02.71	Encounter for disability determination	ICD10CM
Z02.79	Encounter for issue of other medical certificate	ICD10CM
Z02.81	Encounter for paternity testing	ICD10CM
Z02.82	Encounter for adoption services	ICD10CM
Z02.83	Encounter for blood-alcohol and blood-drug test	ICD10CM
Z02.89	Encounter for other administrative examinations	ICD10CM
Z02.9	Encounter for administrative examinations, unspecified	ICD10CM

IMA-2: Immunization for Adolescents

Adult	Family Practice	Pediatrics
Not Included	Reporting-Only	Incentive-eligible

Source: Combination 2 rate of the NCQA HEDIS metric IMA-E.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

Denominator: Assigned HPSM Medi-Cal members who turn 13 years of age during the measurement year.

Additional exclusions:

- Members not enrolled in Medi-Cal on their 13th birthday.
- Members not enrolled in Medi-Cal throughout the 365 days prior to their 13th birthday.
- Members with more than one gap in Medi-Cal enrollment of up to 45 days during the 365 days prior to the member's 13th birthday.

Numerator: Members meeting denominator inclusion criteria for whom HPSM received sufficient documentation of compliance with all three indicators:

- Meningococcal Serogroups A, C, W, Y:
    - At least one meningococcal vaccine (serogroups A, C, W, Y or A, C, W, Y, B) with a date of service on or between the member's 10th and 13th birthdays.
    - Anaphylaxis due to the meningococcal vaccine any time on or before the member's 13th birthday.
- Tetanus, diphtheria toxoids and acellular pertussis (Tdap):
    - At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine with a date of service on or between the member's 10th and 13th birthdays.
    - Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday.
    - Encephalitis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday.
- Human papillomavirus (HPV):

- At least two HPV vaccines on or between the member's 9th and 13th birthdays and with dates of service at least 146 days apart. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be on or after July 25.
- At least three HPV vaccines with different dates of service on or between the member's 9th and 13th birthdays.
- Anaphylaxis due to the HPV vaccine any time on or before the member's 13th birthday.

IMA Procedure Codes

Code	Definition	Code System
90649	HPV Vaccine Administered	CPT
90650	HPV Vaccine Administered	CPT
90651	HPV Vaccine Administered	CPT
90734	Meningococcal Vaccine Administered	CPT
90715	Tdap Vaccine Administered	CPT

LSC: Lead Screening in Children

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Incentive-eligible

Source: NCQA HEDIS metric of the same name.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Denominator: Children who turn 2 years old during the measurement year.

Numerator: At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday.

KED: Kidney Health Evaluation for Patients with Diabetes

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Not included

Source: NCQA HEDIS metric of the same name.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

Denominator: Assigned HPSM Medi-Cal members 18-85 years of age with a diagnosis of diabetes (type 1 or type 2).

Additional exclusions:

- Members with a diagnosis of ESRD any time during the member's history on or prior to December 31 of the measurement year.
- Members who had dialysis any time during the member's history on or prior to December 31 of the measurement year.

Numerator: Members meeting denominator inclusion criteria for whom HPSM received sufficient documentation that both an eGFR and a uACR during the measurement year on the same or different dates of service:

- At least one estimated glomerular filtration rate (eGFR)
- At least one urine albumin-creatinine ratio (uACR) identified by either of the following:
    - Both a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart.
        - For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year.
- A uACR lab test result

eGFR and uACR Procedure Codes

Code	Code System
80047	CPT
80048	CPT
80050	CPT
80053	CPT
80069	CPT
82565	CPT
82043	CPT
82570	CPT

PCR: Plan All-Cause Readmissions

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Not Included

Source: NCQA HEDIS metric of the same name.

Type: Percentage.

Aim: Lower percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal 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: Assigned HPSM Medi-Cal 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 (12 years and older)

Adult	Family Practice	Pediatrics
Incentive-eligible	Reporting-Only	Incentive-eligible

Source: HPSM internal metric.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal 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 Medi-Cal 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
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

SDoH: Z-Coding for Social Determinants of Health

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	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 Medi-Cal members who had at least one eligible z-code reported during the measurement year.

Denominator: All assigned HPSM Medi-Cal 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
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)

Z-Code	Description
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)
Z73.6	Limitation of activities due to disability
Z74.0	Reduced mobility
Z74.01	Bed confinement status
Z74.09	Other Reduced Mobility
Z99.0	Dependence on aspirator

Z-Code	Description
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

TBC: Tobacco Use Screening and Cessation Intervention (12 years and older)

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Incentive-eligible

Source: HPSM internal metric.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: Percentage of assigned HPSM Medi-Cal members 12 years of age and older who were screened for tobacco use using a validated screening tool (e.g., CRAFFT, S2BI, etc.) at least once during the measurement year AND who received tobacco cessation intervention if identified as a tobacco user.

Please visit https://www.hpsm.org/provider/value-based-payment for a list of covered tobacco cessation services, including medications covered by Medi-Cal Rx.

Denominator: All assigned HPSM Medi-Cal members 12 years and older with at least one preventive encounter OR two outpatient encounters during the measurement year.

Numerator: Members who meet the denominator criteria and have evidence of tobacco screening and cessation intervention (if identified as a tobacco user) performed during the measurement year using procedure codes 99406, 99407, 4004F, 1036F.

Tobacco Screening Procedure Codes

Screening Result	Code	Definition	Code System
Tobacco Use Present	**99406**	Smoking and tobacco use cessation counseling visit; intermediate, between 3-10 minutes	CPT
	99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	CPT
	4004F	Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user	CPT

Tobacco Use NOT Present	**1036F**	Current tobacco non-user OR Tobacco Screening not Performed OR Tobacco Cessation Intervention not Provided for Medical Reasons	CPT-II

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

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Not included

Source: Rate 4 of NCQA HEDIS metric TRC.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of discharges for assigned HPSM Medi-Cal 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 Medi-Cal 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

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Not included

Source: Rate 3 of NCQA HEDIS metric TRC.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of discharges for assigned HPSM Medi-Cal 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 Medi-Cal 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

WCC-BMI: Weight Assessment for Children/Adolescents

Adult	Family Practice	Pediatrics
Not Included	Reporting-Only	Reporting-Only

Source: Rate 1 of the NCQA HEDIS metric WCC.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during the measurement year.

Denominator: Assigned HPSM Medi-Cal members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN during 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 year.

Numerator: Members meeting denominator inclusion criteria with evidence of BMI percentile documentation during the measurement year as identified by administrative data or medical record review. The percentile ranking is based on the CDC's BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among others of the same gender and age. Because BMI norms for youth vary with age and gender, this metric evaluates whether BMI percentile is assessed rather than an absolute BMI value.

- Documentation must include height, weight and BMI percentile during the measurement year.
    - The height, weight and BMI percentile must be from the same data source.
- Either of the following meets criteria for BMI percentile:
    - BMI percentile documented as a value (e.g., 85th percentile).
    - BMI percentile plotted on an age-growth chart.
- Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.
- Member-collected biometric values (height, weight, BMI percentile) that meet the requirements.
- Documentation of >99% or <1% meets criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).

Additional numerator exclusions:

- Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance.

BMI Percentile Diagnosis Codes

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

WCC-N: Weight Assessment and Counseling for Nutrition for Children/Adolescents

Adult	Family Practice	Pediatrics
Not Included	Reporting-Only	Incentive-eligible

Source: Rate 2 of the NCQA HEDIS metric WCC.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of nutrition counseling based on their BMI percentile.

Denominator: Assigned HPSM Medi-Cal members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN during 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 year.

Numerator: Members meeting denominator inclusion criteria with documentation of counseling for nutrition or referral for nutrition education during the measurement year as identified by administrative data or medical record review.

- Documentation must include a note indicating the date and at least one of the following:
    - Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
    - Checklist indicating nutrition was addressed.
    - Counseling or referral for nutrition education.
    - Member received educational materials on nutrition during a face-to-face visit.
    - Anticipatory guidance for nutrition.
    - Weight or obesity counseling.

Nutrition Counseling Procedure Codes

Code	Definition	Code System
97802		CPT
97803		CPT
97804		CPT
G01270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	HCPCS
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes	HCPCS
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	HCPCS
S9449	Weight management classes, non-physician provider, per session	HCPCS
S9452	Nutrition classes, non-physician provider, per session	HCPCS
S9470	Nutritional counseling, dietitian visit	HCPCS
Z71.3	Dietary counseling and surveillance	ICD10CM

WCC-PA: Weight Assessment and Counseling for Physical Activity for Children/Adolescents

Adult	Family Practice	Pediatrics
Not Included	Reporting-Only	Incentive-eligible

Source: Rate 3 of the NCQA HEDIS metric WCC.

Type: Percentage

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of physical activity counseling based on their BMI percentile.

Denominator: Assigned HPSM Medi-Cal members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN during 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 year.

Numerator: Members meeting denominator inclusion criteria with documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by administrative data or medical record review.

- Documentation must include a note indicating the date and at least one of the following:
    - Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
    - Checklist indicating physical activity was addressed.
    - Counseling or referral for physical activity.
    - Member received educational materials on physical activity during a face-to-face visit.
    - Anticipatory guidance specific to the child's physical activity.
    - Weight or obesity counseling.

Physical Activity Counseling Procedure Codes

Code	Definition	Code System
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	HCPCS
S9451	Exercise classes, non-physician provider, per session	HCPCS
Z02.5	Encounter for examination for participation in sport	HCPCS
Z71.82	Exercise counseling	ICD10CM

WCV: Child and Adolescent Well-Care Visits (3-21 years of age)

Adult	Family Practice	Pediatrics
Not Included	Incentive-eligible	Incentive-eligible

Source: NCQA HEDIS metric of the same name.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Denominator: Assigned HPSM Medi-Cal members 3–21 years of age during the measurement year.

Additional exclusions:

- Members with more than one gap in enrollment of up to 45 days.

Numerator: Members meeting denominator inclusion criteria for whom HPSM received sufficient evidence of one or more well-care visits during the measurement year.

- The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.
- Annual well child visit for patients 3-21 years old must include:
    - A health, physical developmental, and mental developmental history
    - Complete physical exam
    - Anticipatory guidance and health education
    - Complete the Staying Healthy Assessment (SHA) Questionnaires and Instructions found here: https://www.hpsm.org/provider/resources/forms

Additional numerator Additional exclusions:

- Telehealth visits
- Annual well child visit for patients 3-21 years old must include:
- A health, physical developmental, and mental developmental history
- Complete physical exam
- Anticipatory guidance and health education

Complete the SHA Tool and Instruction Guide found here: hpsm.org/provider-forms

WCV Well Child & Adolescent Visit Procedure Codes

Code	Definition	Code System
99381		CPT
99382	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/ risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures, new patient: early childhood (age 1-4 years)	CPT
99383	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/ risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures, new patient: late childhood (age 5-11 years)	CPT
99384		CPT
99385		CPT
99391		CPT
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1-4 years)	CPT
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5-11 years)	CPT
99394		CPT
99395		CPT
99461		CPT
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

Code	Definition	Code System
S0302	Completed early periodic screening diagnosis and treatment (epsdt) service (list in addition to code for appropriate evaluation and management service) (S0302)	HCPCS
Z00.00	Encounter for general adult medical examination without abnormal findings	ICD10CM
Z00.01	Encounter for general adult medical examination with abnormal findings	ICD10CM
Z00.110	Health examination for newborn under 8 days old	ICD10CM
Z00.111	Health examination for newborn 8 to 28 days old	ICD10CM
Z00.121	Encounter for routine child health examination with abnormal findings	ICD10CM
Z00.129	Encounter for routine child health examination without abnormal findings	ICD10CM
Z00.2	Encounter for examination for period of rapid growth in childhood	ICD10CM
Z00.3	Encounter for examination for adolescent development state	ICD10CM
Z02.0	Encounter for examination for admission to educational institution	ICD10CM
Z02.5	Encounter for examination for participation in sport	ICD10CM
Z02.6	Encounter for examination for insurance purposes	ICD10CM
Z76.1	Encounter for health supervision and care of foundling	ICD10CM
Z76.2	Encounter for health supervision and care of other healthy infant and child	ICD10CM

W30-6: Well-Child Visits in the First 15 Months

Source: Rate 1 of the NCQA HEDIS metric W30.

Type: Percentage.

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members who turned 15 months old during the measurement year and had six or more well-child visits with a PCP during their first 15 months of life.

Denominator: Assigned HPSM Medi-Cal members who turned 15 months old during the measurement year.

Additional exclusions:

- Members with more than one gap in enrollment of up to 45 days.

Numerator: Members meeting denominator inclusion criteria for whom HPSM received sufficient evidence of six or more well-child visits with a PCP during their first 15 months of life.

- The well-care visit must occur with a primary care provider (PCP), but the practitioner does not have to be the practitioner assigned to the member.
- Annual well child visit for patients 0-15 months old must include:
    - A health, physical developmental, and mental developmental history
    - Complete physical exam
    - Anticipatory guidance and health education

Additional numerator Additional exclusions:

- Telehealth visits

Note that children cannot become Medi-Cal enrolled until the end of the first month of life. To properly capture all well visits completed in the first month of life and mitigate the need for data linkage, providers are encouraged to wait until the infant has received their own Medi-Cal member ID independent of the mother before submitting well visit procedure codes to HPSM.

W15 & W30 Well Child Visit Procedure Codes

Code	Definition	Code System
99381		CPT
99382		CPT
99383		CPT
99384		CPT

99385		CPT
99391		CPT
99392		CPT
99393		CPT
99394		CPT
99395		CPT
99461		CPT
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
S0302	Completed early periodic screening diagnosis and treatment (epsdt) service (list in addition to code for appropriate evaluation and management service	HCPCS
Z00.00	Encounter for general adult medical examination without abnormal findings	ICD10CM
Z00.01	Encounter for general adult medical examination with abnormal findings	ICD10CM
Z00.110	Health examination for newborn under 8 days old	ICD10CM
Z00.111	Health examination for newborn 8 to 28 days old	ICD10CM
Z00.121	Encounter for routine child health examination with abnormal findings	ICD10CM
Z00.129	Encounter for routine child health examination without abnormal findings	ICD10CM
Z00.2	Encounter for examination for period of rapid growth in childhood	ICD10CM
Z00.3	Encounter for examination for adolescent development state	ICD10CM
Z02.5	Encounter for examination for participation in sport	ICD10CM
Z76.1	Encounter for health supervision and care of foundling	ICD10CM
Z76.2	Encounter for health supervision and care of other healthy infant and child	ICD10CM

W30-2: Well-Child Visits for Age 15–30 Months

Adult	Family Practice	Pediatrics
Not Included	Reporting-Only	Reporting-Only

Source: Rate 2 of the NCQA HEDIS metric W30.

Type: Percentage

Aim: Higher percentage indicates quality performance.

Definition: The percentage of assigned HPSM Medi-Cal members who turned 30 months old during the measurement year and had two or more well-child visits with a primary care provider (PCP) between the child's 15-month birthday plus one day and 30-month birthday.

Denominator: Assigned HPSM Medi-Cal members who turned 30 months old during the measurement year.

Additional exclusions:

- Members with more than one gap in enrollment of up to 45 days.

Numerator: Members meeting denominator inclusion criteria for whom HPSM received sufficient evidence of two or more well-child visits with a PCP between the child's 15-month birthday plus one day and 30-month birthday.

- The well-care visit must occur with a primary care provider (PCP), but the practitioner does not have to be the practitioner assigned to the member.
- Annual well child visit for patients 15-30 months old must include:
    - A health, physical developmental, and mental developmental history
    - Complete physical exam
    - Anticipatory guidance and health education

Additional numerator Additional exclusions:

- Telehealth visits

*See procedure code list for W15 and W30 above

VI. 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.

VII. 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.