



Benchmark Pay for Performance **Medi-Cal** Program Guidelines

2024 Program Year - Final Release

Click on [blue underlines](#) throughout to jump to relevant section



You may be looking for the [Care Gap Closure Pay-for-Performance](#) program guidelines administered through Stellar Health.

Summary of Changes to 2024 Medi-Cal Program

Important changes to program:

1. HPSM has launched an alternate P4P program (“Care Gap Closure P4P”) administered by [Stellar Health](#) for the calendar year 2024. The [Stellar Health Application](#) is a web-based, point-of-care tool that displays registries of all patients assigned to a primary care clinic and delivers simple checklists of recommended clinical actions based on each patient’s medical history. Stellar delivers real-time incentive payments for the granular actions providers take to close care gaps such as scheduling visits; delivering well visits, preventive and diagnostic screenings, and immunizations; renewing prescriptions; and submitting claims.

Providers who opt-in to Care Gap Closure P4P are not eligible to participate in this legacy Benchmark P4P program after launching in the Stellar App. PCPs are encouraged to onboard to the Stellar application no later than December 31, 2024 to ensure continued participation in HPSM quality bonus payments. To encourage providers to transition to Care Gap P4P, HPSM makes the following commitments for the 2024 program:

- a. Clinics that launch in the Stellar App by March 31, 2024 will earn +20% additional bonus dollars for every Stellar action through the end of CY2024.
- b. Clinics that launch in Stellar between February 1 and December 31, 2024 will still be paid a MY2024 Benchmark P4P payment prorated to the number of full calendar year months before they launched in Stellar. In other words, a clinic that launches in Stellar March 1 2024 will not have been able to earn Stellar bonus dollars in January and February, so HPSM will instead calculate what their Benchmark P4P payment for MY2024 would have been times one-sixth, since they participated in Benchmark P4P only for two months or one-sixth of 2024.
- c. If between clinic launching in Stellar and December 31, 2024, clinic earns less in Stellar bonus payments than what they would have earned had they remained in Benchmark P4P for those prorated months, then HPSM will cut a check with the difference for this first year.

For questions about HPSM Care Gap Closure Pay-for-Performance (Care Gap P4P), see the FAQ section in the Care Gap Closure P4P Program Guidelines [here](#) or contact HPSM Provider Services at PSInquiries@hpsm.org.

Changes to quality metrics eligible for payment, by program track:

1. **No changes to Benchmark P4P quality metric sets from MY2023** – all payment metrics remain consistent from prior year. See pages 8 (Adult), 10 (Family Practice), and 12 (Pediatrics) for MY2024 benchmarks and refer to the August 2023 HEDIS release for the best source of truth for procedure and diagnosis coding.

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I. Program Overview

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

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

Provider Eligibility

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

1. Clinic participates in HPSM primary care partial capitation;
2. Clinics must have a Medi-Cal primary care contract with HPSM active as of the measurement period start date through at least six months following the close of the measurement period;
3. Providers must have 100 HPSM Medi-Cal members assigned to their panel as of January 1st, 2024. If clinic assignment falls below 100 Medi-Cal members at any point during the measurement period, clinic may be asked to accept additional member assignment until the 100 minimum is achieved again in order to qualify for bonus.
4. Provider group is not currently opted-in to Care Gap Closure P4P program administered by Stellar Health.

Program Tracks

All participating providers are eligible for percent increases to capitation payments based on [panel engagement](#).

Medi-Cal providers will be assigned one of three program sub-tracks based on the approximate age range of members assigned to their clinic(s):

- **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 ranges

Quality Metric Selection

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

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

Program Benchmarks

Standard Benchmarks

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

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

Benchmarks may be retro-adjusted downward in the event no clinic meets the full credit benchmark. Decisions to adjust benchmarks are made during the payment calculation process after all data reconciliation activities 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 prior year. A minimum 10% improvement “on the negative” is required to earn partial credit if partial credit benchmark is not otherwise reached.

- Ex 1: If MY2023 rate = 10%, then MY2024 partial credit awarded at $\geq 19\%$ (10% improvement on 90% non-compliance)
- Ex 2: If MY2023 rate = 90%, then MY2024 partial credit awarded at $\geq 91\%$ (10% improvement on 10% non-compliance)

Data Reports and Additional Coding Resources

Performance bonus payment in the Benchmark P4P program is contingent on meeting the specified metric benchmarks for assigned patients who meet the metric criteria. Once the encounter information has been received and eligibility has been determined, providers will get credit towards the annual benchmark. Monthly member detail benchmark progress reports are available to providers through the HPSM eReports portal. Reports for the 2024 Program Year will be published **at the beginning of each month between July 2024 and April 2025**. The website for eReports login is: <https://reports.hpsm.org>. Additional resources, including an eReports User Guide, coding guidelines, and code lists are available at: <https://www.hpsm.org/provider/value-based-payment>.

Program Timeline

Period	Dates (subject to change)	Description
Program Year	01/01/2024 – 12/31/2024	This is the anchor program year for all dates of service (DOS). For metrics with a lookback period of multiple years, count 2024 as year 1.
Supplemental Data Submission Deadline	03/08/2025	All supplemental data (EMR extracts, lab submissions) must be submitted by this date to ensure timely processing for bonus payments.
Claims Submission Deadline	02/28/2025	All HPSM claims and qualifying codes must be submitted by this date to ensure timely processing for bonus payments.

Attestation Period	04/02/2025 – 04/30/2025	Providers may manually attest for compliance in cases where the claims submission process has not captured all relevant data. Instructions for attestation will be distributed Spring 2025.
Payment Finalization	05/01/2025 – 06/30/2025	HPSM compiles all performance data and calculates bonus payment using the formula below. Bonus is distributed via lump sum as a single check mailed to the financial address on file.

Incentive Payment Formula

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

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

Formula Term Definitions

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

Composite Quality Score: Average score for all earned quality points based on final performance rate following the program calendar year. **For MY2024, 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 eligible patient in the denominator. If eligible patients is zero, provider is considered ineligible for that assigned metric and it is excluded from their composite quality score calculation.

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

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

II. Adult Track 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 quality metric set. These metrics are in addition to the special metric measuring panel engagement for quarterly capitation bonuses.

Adult Payment Quality Metric Set

Clinics earn quality score points for each payment metric in which their performance meets or exceeds the full or partial credit benchmark for that metric. For all MY2024 payment metric, earning full credit nets two (2) quality score points and partial credit nets one (1) point.

Shorthand	Payment Metric Name	Metric Source	Performance Benchmarks	
			Full Credit	Partial Credit ⁱ
BCS	Mammogram for Breast Cancer Screening	HEDIS	63 %	59 %
BPD	Blood Pressure Control for Patients with Diabetes	HEDIS	58 %	47 %
CBP	Controlling High Blood Pressure	HEDIS	71 %	59 %
CCS	Cervical Cancer Screening	HEDIS	65 %	59 %
CDF	Depression Screening and Follow-Up (12 years and older)	HPSM	61 %	48 %
EED	Eye Exam for Patients with Diabetes	HEDIS	65 %	59 %
FLU	Seasonal Influenza Vaccine	HPSM	72 %	64 %
HBD-2*	Hemoglobin A1c Control (>9.0%) for Patients with Diabetes	HEDIS	25 %	33 %
IHA	Initial Health Appointment	HPSM	65 %	55 %
SBIRT	Substance Misuse Screening	HPSM	56 %	43 %

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

Engagement	Panel Engagement for Capitation Bonuses	HPSM	60%	50 - 59.99%
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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, though these metrics are not included in payment calculations. While provider performance is not measured against payment benchmarks, HPSM shares back prior year network performance data in an effort to continuously improve performance.

Shorthand	Reporting-Only Metric Name	Metric Source
ACE	Trauma Screening (Adverse Childhood Experiences)	HPSM
AMB-ED	Ambulatory Emergency Department Visits	HEDIS
Avoid-ED	Avoidable Emergency Department Visits	HPSM
CDM	Comprehensive Diabetes Management	HPSM
CHA	Cognitive Health Assessment	HPSM
CHL	Chlamydia Screening in Women (16-24 years old)	HEDIS
Encounters	Encounter Threshold – reported as average visits per member per year	HPSM
HBD-1	Hemoglobin A1c Control (<8.0%) for Patients with Diabetes	HEDIS
PCR	Plan All-Cause Readmissions	HEDIS
SDoH	Z-Coding for Social Determinants of Health	HPSM
TBC	Tobacco Use Screening and Cessation Intervention (12 years and older)	HPSM

III. Family Practice Track 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. These metrics are in addition to the special metric measuring panel engagement for quarterly capitation bonuses.

Family Practice Payment Quality Metric Set

Providers earn quality score points for each payment metric in which their performance meets or exceeds the full or partial credit benchmark for that metric. For all MY2024 payment metrics, earning full credit nets two (2) quality score points and partial credit nets one (1) point.

Shorthand	Payment Metrics Name	Metrics Source	Performance Benchmarks	
			Full Credit	Partial Credit ⁱⁱ
BCS	Mammogram for Breast Cancer Screening	HEDIS	63 %	59 %
CBP	Controlling High Blood Pressure	HEDIS	65 %	52 %
CCS	Cervical Cancer Screening	HEDIS	68 %	65 %
CDF	Depression Screening & Follow Up (12 years and older)	HEDIS	60 %	49 %
EED	Eye Exam for Patients with Diabetes	HEDIS	65 %	59 %
FLU	Seasonal Influenza Vaccine	HPSM	60 %	56 %
HBD-2*	Hemoglobin A1c Control (>9.0%) for Patients with Diabetes	HEDIS	25 %	34 %
IHA	Initial Health Appointment	HEDIS	75 %	62 %
W15	Well Child Visit (0-15 months old)	HEDIS	64 %	56 %
WCV	Well Child and Adolescent Visit (3 – 21 years old)	HEDIS	57 %	52 %

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

Engagement	Panel Engagement for Capitation Bonuses	HPSM	60%	50 - 59.99%
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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, though these metrics are not included in payment calculations. While provider performance is not measured against payment benchmarks, HPSM shares back prior year network performance data in an effort to continuously improve performance.

Shorthand	Reporting-Only Metric Name	Metric Source
ACE	Trauma Screening (Adverse Childhood Experiences)	HPSM
AMB-ED	Ambulatory Emergency Department Visits	HEDIS
Avoid-ED	Avoidable Emergency Department Visits	HPSM
CDM	Comprehensive Diabetes Management	HPSM
CHA	Cognitive Health Assessment	HPSM
CHL	Chlamydia Screening in Women (16 – 24 years old)	HEDIS
CIS-10	Childhood Immunizations (Combination 10)	HEDIS
DEV	Developmental Screening	HPSM
Encounters	Encounter Threshold – reported as average visits per member per year	HPSM
FVN	Fluoride Varnish	HPSM
HBD-1	Hemoglobin A1c Control (<8.0%) for Patients with Diabetes	HEDIS
PCR	Plan All-Cause Readmissions	HEDIS
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
W30	Well Child Visit (15-30 months)	HEDIS
WCC-BMI	Pediatric BMI Assessment	HEDIS
WCC-N	Nutrition Counseling for Children	HEDIS
WCC-PA	Physical Activity Counseling for Children	HEDIS

IV. Pediatric Track 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. These metrics are in addition to the special metric measuring panel engagement for quarterly capitation bonuses.

Pediatric Payment Quality Metric Set

Providers earn quality score points for each payment metric in which their performance meets or exceeds the full or partial credit benchmark for that metric. For all MY2024 payment metrics, earning full credit nets two (2) quality score points and partial credit nets one (1) point.

Shorthand	Payment Metric Name	Metric Source	Performance Benchmarks	
			Full Credit	Partial Credit ⁱⁱⁱ
CDF	Depression Screening and Follow Up (12 years and older)	DHCS	76 %	63 %
CIS-10	Childhood Immunizations (Combination 10)	HEDIS	56 %	46 %
FLU	Seasonal Influenza Vaccine	HPSM	72 %	66 %
IMA-2	Immunizations for Adolescent (Combination 2)	HEDIS	64 %	59 %
SBIRT	Substance Misuse Screening	HEDIS	60 %	46 %
TBC	Tobacco Use Screening and Cessation Intervention (12 years and older)	HPSM	59 %	43 %
W15	Well Child Visit (0-15 months old)	HEDIS	65 %	57 %
WCC-N	Weight Assessment & Nutrition Counseling for Children	HEDIS	75 %	61 %
WCC-PA	Weight Assessment & Physical Activity Counseling for Children	HEDIS	72 %	56 %
WCV	Well Child and Adolescent Visit (3-21 years old)	HEDIS	64 %	60 %

Engagement	Panel Engagement for Capitation Bonuses	HPSM	60%	50 - 59.99%
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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, though these metrics are not included in payment calculations. While provider performance is not measured against payment benchmarks, HPSM shares back prior year network performance data in an effort to continuously improve performance.

Shorthand	Reporting-Only Metric Name	Metric Source
ACE	Trauma Screening (Adverse Childhood Experiences)	HPSM
AMR	Asthma Medication Ratio	HEDIS
Avoid-ED	Avoidable Emergency Department Visit	HPSM
CHL	Chlamydia Screening in Women (16-24 years old)	HEDIS
DEV	Developmental Screening	HPSM
Encounters	Encounter Threshold – reported as average visits per member per year	HPSM
FVN	Fluoride Varnish	HPSM
IHA	Initial Health Appointment	HPSM
IMA-2	Adolescent Immunizations (Combination 2)	HEDIS
SBIRT	Substance Misuse Screening and Follow Up (12 years and older)	HPSM
SDoH	Z-Coding for Social Determinants of Health	HPSM
W30	Well Child Visit (15-30 months old)	HEDIS

V. Panel Engagement – Capitation Bonuses and Corrective Action

Panel Engagement Overview

Access to primary care is a key driver for managing the health of our shared patient population and we want to recognize the work our providers do to engage assigned HPSM patients at their clinics/offices. Capitated clinics will be eligible to earn up to an additional 30% of capitation each month based on quarterly panel engagement:

- **30% additional capitation:** Clinic has had at least one eligible encounter with an average 60% or greater of continuously assigned members over a rolling 12 month timeline.
- **15% additional capitation:** Clinic has had at least one eligible encounter with an average 50-59.99% of continuously assigned members over a rolling 12 month timeline.
- **Base capitation only:** Clinic has had at least one eligible encounter with an average 35 - 49.99% of continuously assigned members over a rolling 12 month timeline.
- **Base capitation only with Corrective Action Plan:** Clinic has had at least one eligible encounter with an average 0 – 34.99% of continuously assigned members over a rolling 12 month timeline. Clinics with low panel engagement for two consecutive quarters may be placed on a Corrective Action Plan (CAP) and face sanctions including being temporarily placed on mandated Established Patients Only (EPO) status to prevent further member assignment, being temporarily transitioned to a fee-for-service reimbursement structure, or termination from the network.

Eligible primary care encounters that count towards patient engagement:

- Any claims received from rendering providers at the assigned primary care clinic that fall into any of the following primary care specialty designations – general medicine, internal medicine, family medicine, geriatrics, pediatrics, certified nurse practitioner, and physician assistant
- AND preventive services billed by non-PCP specialty types at assigned clinic - (**99381-99387, 99391-99397, 99401-99429, G0402, G0438, G0439, S0612**);
- Codes for immunization: **99460-90749, G0008-G0010, Q2034-Q2039**;
- Encounters for COVID-19 immunization administered by assigned primary care clinic;
- AND telemedicine based on billable definitions and telephone visit codes - (**98966, 98967, 98968, 99441, 99442, 99443**);
- AND capitated encounters

Clinics receive monthly performance reports describing primary care engagement. The engagement performance benchmark is averaged over the quarter and capitation bonus payments will be based on the quarter performance benchmark average. Payments are made prospectively for the entire following quarter.

VI. Quality Metric Specifications

ACEs: Trauma Screening

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

Metric Source: DHCS, under Proposition 56 directed payments.

Patient Eligibility: Members under age 21.

Metric Definition: Percentage of members under age 21 screened for ACEs (Adverse Childhood Experiences) using the PEARLS tool during the measurement year.

ACEs Trauma Screenings are not eligible for P4P payments or credit for the 2024 Program Year. However, eligible providers will continue to receive directed payments of \$35.67 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 CME/MOC credits through this training.

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

Trauma Screening Procedure Codes

Code	Definition	Code System
G9919	Trauma Screening	HCPCS
G9920	Trauma Screening	HCPCS

AMB-ED: Ambulatory Emergency Care

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

Metric Source: HPSM internal metric.

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

Exclusions:

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

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

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

Avoid-ED: Avoidable Emergency Department Visits

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

Metric Source: HPSM internal metric.

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

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

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

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

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

BCS: Mammogram for Breast Cancer Screening

Adult	Family Practice	Pediatrics
Payment	Payment	Not Included

Metric Source: HEDIS metric of the same name.

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

Exclusions:

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

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

Mammography Procedure Codes

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

Mammography Exclusion Code

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

BPD: Blood Pressure Control for Patients with Diabetes

Adult	Family Practice	Pediatrics
Payment	Payment	Not Included

Metric Source: HEDIS metric of the same name (formerly Rate 6 of the retired HEDIS metric, CDC).

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

Exclusions:

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

Metric Definition: The percent of diabetic patients who had a blood pressure reading and are in control for the most recent blood pressure reading. Must include both systolic and diastolic blood pressure results as documented through administrative data. To qualify, the most recent BP level (taken during the current calendar year) is <140/90 mm Hg, as documented through administrative data or medical record review.

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
Payment	Payment	Not Included

Metric Source: HEDIS metric of the same name.

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

Exclusions:

- Members 66-80 years old with both frailty AND advanced illness
- Members 81 years of age and older as of December 31 of the measurement year with frailty
- Members with evidence of end-stage renal disease (ESRD), dialysis, nephrectomy, or kidney transplant on or prior to December 31 of the measurement year
- Members with a diagnosis of pregnancy during the measurement year
- Members who had a nonacute inpatient admission during the measurement year
- Members receiving palliative care

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

Hypertension Diagnosis Code

Code	Definition	Code System
I10	Essential (primary) hypertension	ICD10CM

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: Cervical Cancer Screening

Adult	Family Practice	Pediatrics
Payment	Payment	Not Included

Metric Source: HEDIS metric of the same name.

Patient Eligibility: Women 21-64 years old.

Exclusions:

- Exclude members receiving hospice or palliative care during the measurement year.
- 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](#)”)

Metric Definition: The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21–64 years of age who had cervical cytology performed every 3 years (36 calendar months).
- Women 30–64 years of age who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years (72 calendar months).
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing every 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
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)	HPCPS

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

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

Adult	Family Practice	Pediatrics
Payment	Payment	Payment

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](https://www.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 standardized 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

CDM: Comprehensive Diabetes Management

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

Metric Source: HPSM internal metric (formerly known as CDC-Complete).

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

Exclusions:

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

Metric Definition: Percent of assigned diabetic patients who had their most recent eligible result of hemoglobin A1c controlled ([HBD-1](#)), blood pressure controlled ([BPD](#)), retinal eye exam administered ([EED](#)), and kidney health evaluation performed ([KED](#)) in the relevant lookback period for each component metric.

CHA: Cognitive Health Assessment

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

Metric Source: HPSM internal metric, directed by [APL 22-025](#).

Patient Eligibility: Medi-Cal members 65 and older.

Metric Definition: The percentage of 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.

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

Metric Source: HEDIS metric of the same name.

Patient Eligibility: Women 16-24 years old who are sexually active.

Metric Definition: The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the calendar year.

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	Payment

Metric Source: Combination 10 of the HEDIS metric CIS.

Patient Eligibility: Children who turn 2 years old during the current calendar year.

Exclusions: Exclude children who had a contraindication for a specific vaccine by their 2nd birthday from the denominator for all antigen rates and the combination rates.

Metric Definition: The percentage of children 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. The metric calculates a rate for each vaccine and nine separate combination rates.

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
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

DEV: Developmental Screening

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

Metric Source: DHCS, under Proposition 56 directed payments.

Patient Eligibility: Children 30 months of age.

Metric Definition: Percentage of children 30 months of age who have received developmental screening by 9 months, 18 months and 30 months of age.

Developmental Screenings are not eligible for P4P payments or credit for the 2024 Program Year. However, providers will continue to receive directed payments via Proposition 56 funds. Providers receive \$73.68 for each eligible developmental screening performed and reported using the CPT code 96110. **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>

Providers must use a validated and age-appropriate screening instrument and document results in the medical record. The following tools are currently 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)

Developmental Screening Procedure Code

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

EED: Eye Exam for Patients with Diabetes

Adult	Family Practice	Pediatrics
Payment	Payment	Not Included

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

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

Exclusions:

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

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

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

Diabetic Retinal Eye Exam Procedure Codes

Code	Definition	Code System
67028	Diabetic Retinal Screening	CPT
67030	Diabetic Retinal Screening	CPT
67031	Diabetic Retinal Screening	CPT
67036	Diabetic Retinal Screening	CPT
67039	Diabetic Retinal Screening	CPT
67040	Diabetic Retinal Screening	CPT
67041	Diabetic Retinal Screening	CPT
67042	Diabetic Retinal Screening	CPT
67043	Diabetic Retinal Screening	CPT
67101	Diabetic Retinal Screening	CPT
67105	Diabetic Retinal Screening	CPT

67107	Diabetic Retinal Screening	CPT
67108	Diabetic Retinal Screening	CPT
67110	Diabetic Retinal Screening	CPT
67113	Diabetic Retinal Screening	CPT
67121	Diabetic Retinal Screening	CPT
67141	Diabetic Retinal Screening	CPT
67145	Diabetic Retinal Screening	CPT
67208	Diabetic Retinal Screening	CPT
67210	Diabetic Retinal Screening	CPT
67218	Diabetic Retinal Screening	CPT
67220	Diabetic Retinal Screening	CPT
67221	Diabetic Retinal Screening	CPT
67227	Diabetic Retinal Screening	CPT
67228	Diabetic Retinal Screening	CPT
92002	Diabetic Retinal Screening	CPT
92004	Diabetic Retinal Screening	CPT
92012	Diabetic Retinal Screening	CPT
92014	Diabetic Retinal Screening	CPT
92018	Diabetic Retinal Screening	CPT
92019	Diabetic Retinal Screening	CPT
92134	Diabetic Retinal Screening	CPT
92225	Diabetic Retinal Screening	CPT
92226	Diabetic Retinal Screening	CPT
92227	Diabetic Retinal Screening	CPT
92228	Diabetic Retinal Screening	CPT
92230	Diabetic Retinal Screening	CPT
92235	Diabetic Retinal Screening	CPT
92240	Diabetic Retinal Screening	CPT

92250	Diabetic Retinal Screening	CPT
92260	Diabetic Retinal Screening	CPT
99203	Diabetic Retinal Screening	CPT
99204	Diabetic Retinal Screening	CPT
99205	Diabetic Retinal Screening	CPT
99213	Diabetic Retinal Screening	CPT
99214	Diabetic Retinal Screening	CPT
99215	Diabetic Retinal Screening	CPT
99242	Diabetic Retinal Screening	CPT
99243	Diabetic Retinal Screening	CPT
99244	Diabetic Retinal Screening	CPT
99245	Diabetic Retinal Screening	CPT
S0620	Diabetic Retinal Screening	HCPCS
S0621	Diabetic Retinal Screening	HCPCS
S3000	Diabetic Retinal Screening	HCPCS
3072F	Diabetic Retinal Screening Negative	CPT II
2022F	Diabetic Retinal Screening With Eye Care Professional	CPT II
2023F	Diabetic Retinal Screening With Eye Care Professional	CPT II
2024F	Diabetic Retinal Screening With Eye Care Professional	CPT II
2025F	Diabetic Retinal Screening With Eye Care Professional	CPTII
2026F	Diabetic Retinal Screening With Eye Care Professional	CPTII
2033F	Diabetic Retinal Screening With Eye Care Professional	CPT II
65091	Unilateral Eye Enucleation	CPT
65093	Unilateral Eye Enucleation	CPT
65101	Unilateral Eye Enucleation	CPT
65103	Unilateral Eye Enucleation	CPT
65105	Unilateral Eye Enucleation	CPT
65110	Unilateral Eye Enucleation	CPT

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

FLU: Seasonal Influenza Vaccination

Adult	Family Practice	Pediatrics
Payment	Payment	Payment

Metric Source: HPSM internal metric.

Patient Eligibility: All members 6 months and older.

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

Metric Definition: The percentage of members 6 months and older receiving a seasonal flu vaccination July 1, 2024 through March 31, 2025.

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

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

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

Flu Vaccine Procedure Codes

Code	Definition	Code System
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	CPT
90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use	CPT
90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use	CPT
90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use	CPT
90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use	CPT
90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use	CPT
90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use	CPT
90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use	CPT
90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	CPT
90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use	CPT
90673	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	CPT

90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	CPT
90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	CPT
90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use	CPT
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use	CPT
90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use	CPT
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use	CPT
90689	Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use	CPT
90694	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use	CPT
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use	CPT
Q2034	Influenza virus vaccine, split virus, for intramuscular use (agriflu)	HCPCS
Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria)	HCPCS
Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval)	HCPCS
Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluvirin)	HCPCS
Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone)	HCPCS
Q2039	Influenza virus vaccine, not otherwise specified	HCPCS
G0008	Administration of influenza virus vaccine	HCPCS

FVN: Fluoride Varnish

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

Metric Source: HPSM internal metric.

Patient Eligibility: Members ages 0-5.

Metric Definition: Percentage of members ages 0-5 who have received fluoride varnish at least two times during 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

HBD-1: Hemoglobin A1c Control (<8.0%) for Patients with Diabetes

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

Metric Source: Rate 1 of the HEDIS metric of the same name (formerly Rate 3 of the retired HEDIS metric, CDC).

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

Exclusions:

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

Metric Definition: Percent of diabetic members whose most recent HbA1c level (performed during the current calendar year) is <8.0% as identified by automated laboratory data or administrative data if laboratory data is not received.

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

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

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

Diabetes HbA1c Procedure Codes

Code	Definition	Code System
3044F	HbA1c Level Less Than 7.0	CPT II
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.

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

Adult	Family Practice	Pediatrics
Payment	Payment	Not Included

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

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

Exclusions:

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

Metric Definition: Percent of diabetic members whose most recent HbA1c level (performed during the current calendar year) is <8.0% as identified by automated laboratory data or administrative data if laboratory data is not received.

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

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

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

Diabetes HbA1c Procedure Codes

Code	Definition	Code System
3044F	HbA1c Level Less Than 7.0	CPT II
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.

IHA: Initial Health Appointment

Adult	Family Practice	Pediatrics
Payment	Payment	Reporting-Only

Metric Source: HPSM internal metric.

Patient Eligibility: Newly enrolled HPSM members (within 120 days of Health Plan enrollment AND 90 days of assignment to primary care panel).

Metric Definition: Percent of newly enrolled and assigned members who had an Initial Health Appointment 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.

A complete IHA must:

1. Be completed by a provider within the primary care medical setting;
2. Be performed in a way that is culturally and linguistically considerate;
3. Be documented in a member’s medical record;
4. 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
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
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
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
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	Payment

Metric Source: Combination 2 rate of the HEDIS metric IMA.

Patient Eligibility: Adolescents who turn 13 years of age during the current calendar year.

Exclusions: Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates.

Metric Definition: The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 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

KED: Kidney Health Evaluation for Patients with Diabetes

Adult	Family Practice	Pediatrics
Reporting-Only <i>(as a standalone measure and a component of CDM)</i>	Reporting-Only <i>(as a standalone measure and a component of CDM)</i>	Not included

Metric Source: HEDIS metric of the same name.

Patient Eligibility: Members 18-85 years of age with a diagnosis of diabetes (types 1 or 2).

Exclusions:

- Members with documented evidence of end-stage renal disease (ESRD) or dialysis at any time during the member’s history
- Members receiving palliative care
- Members with diagnoses of frailty AND advanced illness

Metric Definition: The percentage of 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. Note that this metric corresponds to the HEDIS metric KED (Kidney Health Evaluation).

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

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

Metric Source: HEDIS metric of the same name.

Patient Eligibility: Members 18 and older.

Exclusions:

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

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

SBIRT: Substance Misuse Screening and Follow Up (12 years and older)

Adult	Family Practice	Pediatrics
Payment	Reporting-Only	Payment

Metric Source: HPSM internal metric.

Patient Eligibility: Members 12 years and older.

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

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

Metric Source: HPSM internal metric.

Patient Eligibility: All assigned members.

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

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

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

SDoH Eligible Z-Codes

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

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

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

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Payment

Metric Source: HPSM internal metric.

Patient Eligibility: Assigned members 12 years and older.

Metric Definition: Percentage of patients 12 years and older who were screened for tobacco use using a validated screening tool (i.e. CRAFFT, S2BI, etc.) at least once during the measurement year AND who received tobacco cessation intervention if identified as a tobacco user.

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

Numerator: Patients 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 <u>OR</u> Tobacco Screening not Performed <u>OR</u> Tobacco Cessation Intervention not Provided for Medical Reasons	CPT-II

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.

WCC-BMI: Pediatric Weight Assessment

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

Metric Source: Rate 1 of the HEDIS metric WCC.

Patient Eligibility: Members 3-17 years old.

Exclusions: Exclude female members who have a diagnosis of pregnancy during the measurement year.

Metric Definition: The percentage of 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. For a complete list of outpatient visit codes, please refer to <https://www.hpsm.org/provider/value-based-payment>.

The percentile ranking 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.

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 & Nutrition Counseling for Children

Adult	Family Practice	Pediatrics
Not Included	Reporting-Only	Payment

Metric Source: Rate 2 of the HEDIS metric WCC.

Patient Eligibility: Members 3-17 years old who had evidence of BMI percentile documentation during the calendar year.

Exclusions: Exclude female members who have a diagnosis of pregnancy during the measurement year.

Metric Definition: The percentage of 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. For a complete list of outpatient visit codes, please refer to <https://www.hpsm.org/provider/value-based-payment>.

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 & Physical Activity Counseling for Children

Adult	Family Practice	Pediatrics
Not Included	Reporting-Only	Payment

Metric Source: Rate 3 of the HEDIS metric WCC.

Patient Eligibility: Members 3-17 years old who had evidence of BMI percentile documentation during the calendar year.

Exclusions: Exclude female members who have a diagnosis of pregnancy during the measurement year.

Metric Definition: The percentage of 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. For a complete list of outpatient visit codes, please refer to <https://www.hpsm.org/provider/value-based-payment>.

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: Well Child & Adolescent Visit (3-21 years old)

Adult	Family Practice	Pediatrics
Not Included	Payment	Payment

Metric Source: HEDIS metric of the same name.

Patient Eligibility: Members age 3-21 years old during the calendar year.

Metric Definition: The percentage of members 3–21 years of age who had one or more well-child visits with a PCP during the current calendar year.

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
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

W15: Well Child Visit (0-15 months old)

Adult	Family Practice	Pediatrics
Not Included	Payment	Payment

Metric Source: Rate 1 of the HEDIS metric W30.

Patient Eligibility: Members who turned 15 months old during the measurement year.

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

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

Note that children cannot become Medi-Cal enrolled until the end of the first month of life. In order 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	HCCPS
S0302	Completed early periodic screening diagnosis and treatment (epsdt) service (list in addition to code for appropriate evaluation and management service	HCCPS
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: Well Child Visit (15-30 months old)

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

Metric Source: Rate 2 of the HEDIS metric W30.

Patient Eligibility: Members who turned 30 months old during the measurement year.

Metric Definition: The percentage of members who turned 30 months old during the measurement year and who had two or more well-child visits with a PCP between the child's 15-month birthday plus one day and 30-month birthday.

A 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

[*See procedure code list for W15 and W30 above](#)

VII. Health Education Resources that Support P4P

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

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

VIII. Terms & Conditions

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

In consideration of HPSM's offering of its P4P program, provider agrees to fully and forever release and discharge HPSM from any and all claims, demands, causes of action, and suits, of any nature, pertaining to or arising from the offering by HPSM of the P4P Program.

Any monies paid under the P4P program for services deemed inappropriately submitted will be recouped from future payment. All cases of suspected fraud or abuse will be investigated thoroughly and reported to the appropriate authorities.

HPSM reserves the right to audit medical records to validate services have been completed as billed. If there is evidence of fraud, waste, or abuse, HPSM can recoup P4P payments found to be invalidly billed and the provider could lose privileges to participate in future HPSM P4P programs.

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