✓MetroPlusHealth

2024 Pay for Performance Program

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Program overview

The MetroPlusHealth Pay for Performance (P4P) is an incentive program. It rewards providers for meeting specific goals for delivering quality health care to MetroPlusHealth members enrolled in the Medicaid, CHP, HIV SNP, HARP and Essential Plans. Our goal is to provide the best possible care to our members—your patients.

Eligibility rules

You are **automatically** enrolled and earning in the program when you meet the eligibility rules below.

Minimum Panel Size[1]	• 200 or more to obtain 100% of the program earnings. • 150 –199 to earn 50% of the program earnings *(Access, Availability & Accuracy measures are not applicable.)*
Measure Minimum[1]	Each measure must have 20 or more members in the denominator to qualify for incentive.
Benchmark Tiers[1,2]	2023 New York State Medicaid benchmarks will be used to determine tier amount earned.
Provider Attribution[3]	Provider overall and measure panels are based on PCP assignment on 12/31 of the program year. Members are assigned to their PCP's site.
Medical Record Requests	You must provide requested data and medical records to MetroPlusHealth in a timely manner. This supports MetroPlusHealth's HEDIS® / QARR reporting requirements.
Compliance	Funding to providers under the P4P program is separate from, and not subject to, existing contracts between a provider and MetroPlus Health Plan, Inc. (MetroPlusHealth), including the network participation agreement between MetroPlusHealth and the provider. Because payment under the P4P program is separate from payment pursuant to the provider contract, payment under the P4P program is within MetroPlusHealth's sole discretion and may be withdrawn or discontinued or capped at any time for any reason, including reductions in state or federal funding or payments. To participate in the P4P program, a provider must possess a valid, unencumbered license and be in good standing with all applicable government agencies. Providers must not be under evaluation for or charged with possible fraud, waste and abuse including for issues such as substandard care, inappropriate billing, coding, or medical documentation. To participate in this program, providers must provide data and medical records for MetroPlusHealth HEDIS supplemental data and hybrid medical record collection.

[1] New Member PCP Visit, Social Needs Screening & Follow Up and HIV SNP PCP specific rewards do not have benchmark tiers or panel/measure minimum requirements.

[2] Non-User measure benchmarks will be based on 2023 MetroPlusHealth provider performance.

[3] HIV SNP PCP specific measure panel attribution is based on last PCP seen in the past two years.

What's NEW in 2024?

- ✓ Earn $50 when you see a member within 60 days of the member joining a MetroPlusHealth plan. (Look for "New Member" on the monthly roster.)
- ✓ Earn a reward for screening your MetroPlusHealth patients for Social Determinants of Health & Following Up.
- ✓ HIV PCPs earn $500 when your MetroPlusHealth SNP member reaches viral suppression.
- ✓ Earn up to $3 PMPM reward for responding to Access & Availability surveys with appropriate appointment timeframes.
- ✓ Earn up to $500 a quarter when you submit a roster of provider demographic information to Better Doctor/Quest Analytics.
- ✓ MetroPlusHealth will disburse payment of reward incentive dollars earned in the fall of 2025! Apart from New Member PCP Visit and roster submission to Better Doctor/Quest Analytics, which will be disbursed quarterly.

Program performance reporting

For your site's Quality Reports, including member gaps in care lists and monthly performance summaries, please:	• Send an email to Quality Management at **qmophedis4@metroplus.org**, or • Visit the MetroPlusHealth Provider Portal. Select Resources, P4P Performance and click "Quality Report Request."
For all (P4P and non-P4P) quality measure details, helpful intervention tips, and code requirements:	• Visit **metroplus.org/providers/hedis-qarr-materials** or • Visit the MetroPlusHealth Provider Portal. Select Resources, P4P Performance.
To identify members eligible for you to earn the New Member Visit P4P measure, please download your member roster:	• "New Member" column flagged with a 'Yes' on your PCP roster indicates the member is eligible. Find the roster in the MetroPlusHealth Provider Portal. Select Resources, Reports and click Member Roster.

How payment is calculated and distributed

MetroPlusHealth will pay incentives once a year in the fall after the program year or quarterly. Only the New Member PCP Visit and roster submission to Better Doctor/Quest Analytics will be paid quarterly. We will share your final site performance report for P4P measures when incentives are paid.

Final performance is derived from the total measure award amounts earned across all eligible measures. Measure award amounts are set according to Benchmark Tiers, Per-Member Amount, PMPM or a Quarterly Bonus Amount. See the tables below for measure payment type descriptions and P4P measure awards.

Measure payment type descriptions

Benchmark Tier	Each year, we determine the 50th, 75th and 90th percentiles based on the **prior year** NYS Medicaid QARR benchmarks. It is applied once a year.
Per-Member Amount	This is the award amount per eligible member who receives the required service(s). It is applied once a year or quarterly, depending on the measure.
PMPM	This is the award amount per member per month. It is applied once a year when measure rate requirements are met.
Quarterly Bonus Amount	This is the bonus amount paid when measure requirements are met. It is applied once per quarter.

P4P Measure Awards

P4P Quality Measures	50th	75th	90th	Payment Type
Asthma Medication Ratio	$180	$280	$380	Benchmark Tier
Breast Cancer Screening	$40	$60	$120	Benchmark Tier
Cervical Cancer Screening	$40	$60	$120	Benchmark Tier
Chlamydia Screening	$20	$30	$50	Benchmark Tier
Colorectal Screening	$40	$60	$120	Benchmark Tier
Diabetes Care Eye Exam	$40	$60	$120	Benchmark Tier
Diabetes Kidney Health Evaluation	$20	$30	$50	Benchmark Tier
Non-User Population	$3	$6	$9	Benchmark Tier
Well-child 15 months – 6 visits	$150	$250	$350	Benchmark Tier
Well-child 30 months – 2 visits	$100	$150	$200	Benchmark Tier
Well-child & Adolescent Visit	$50	$70	$130	Benchmark Tier
New in 2024				
New Member PCP Visit w/in 60 days		$50		Per Member
Social Needs – Screening & Follow-Up – 18+		$15		Per Member
HIV SNP PCP Incentives				
Chlamydia/Gonorrhea Testing		$50		Per Member
Flu Shot		$25		Per Member
Syphilis Testing		$50		Per Member
Viral Load Suppression		$500		Per Member
Access, Availability and Accuracy				
Access & Availability Survey Response		Up to $3		PMPM
Provider Roster Submission		Up to $500		Quarterly Bonus

How Benchmark Tier Measures are calculated

The award amount is based on whether your site's measure rate passed the 50th, 75th or 90th percentile. Each measure has a "base award." This will be the amount you receive if you exceed the 50th percentile. If you exceed the 75th or 90th percentile, the award increases at each performance level. Additionally, providers with panel size 200 or greater will receive 100% of their earnings in the program. Providers with 150–199 panel size will receive 50% of earnings in the program. See the example below.

Measures	Award Amount ($)		
	50th Percentile	75th Percentile	90th Percentile
Breast Cancer Screening	$40	$60	$120

Below are examples of different sites' rate (Sites A-D) and award amount when their site exceeded the 50th, 75th or 90th benchmark tier percentiles and their total panel size is above or below the threshold to earn 100% or 50% of earnings.

Site	Site Panel Size	Numerator (members who received the service)	Performance Rate for Site Breast Cancer Screening	Percentile Benchmarks for Breast Cancer Screening			How the Award Amount is Calculated	Award Amount ($)
				50th	75th	90th		
A	2,300	100	50%	69%	71%	73%	0 x $0	$0
B	162	100	70%	69%	71%	73%	(100 x $40)/2	$2,000
C	250	100	72%	69%	71%	73%	100 x $60	$6,000
D	150	100	75%	69%	71%	73%	(100 x $120)/2	$6,000

How Per-Member Measures are calculated

Each measure will have a “base award amount.” That will be multiplied by the number of eligible members who receive the required service(s). Additionally, providers with panel size 200 or greater will receive 100% of their earnings in the program. Providers with 150–199 panel size will receive 50% of earnings in the program. See the example below:

Measure	**Award Amount** ($)
	Per-Member
New Member PCP Visit w/in 60 days*	$50

Below are examples of different sites’ award amounts (Sites A-D) for Per-Member measures when their total panel size is above or below the threshold to earn 100% or 50% of earnings.

Site	**Site Panel Size**	**Numerator** (members who received the service)	**Per-Member Award Amount**	**How the Award Amount is Calculated**	**Award Amount** ($)
A	2,300	1000	$50	1000 x $50	$50,000
B	162	50	$50	(50 x $50)/2	$1,200
C	250	26	$50	26 x $50	$1,300
D	150	100	$50	(100 x $50)/2	$2,500

* New Member Visit incentive will be paid quarterly in addition to the provider’s contracted visit rate.

How PMPM Measures are calculated

Each measure will have a “base award amount.” It is calculated by multiplying by the number of members on your panel when a survey pass rate is met. The Tier 2 rate is the base amount. If you exceed the Tier 2 rate, the award increases. See the example below:

Measure	**Award Amount** ($)*	
	Pass Rate (Tier 1)	**Pass Rate (Tier 2)**
Access and Availability Survey	$3	$2

Below are examples of different sites’ award amounts for PMPM measures when their Pass Rate is at Tier 1 or Tier 2.

Provider Group	**Site Panel Size**	**Actual Pass Rate***	**Pass Rate For Access & Availability Survey**		**How the Award Amount is Calculated**	**Monthly Award Amount**	**Award Amount** ($)
A	2,300	75%	75%	80%	2,300 x $2	$4,600	$55,200
B	2,300	82%	75%	80%	2,300 x $3	$6,900	$82,800

* The actual pass rate will be determined after the full year and is based on a selection of questions.

How Quarterly Bonus Measures are calculated

Each measure will have a “base award amount.” It will be assessed and paid each quarter of the program year. See the example below:

Measures	**Award Amount** ($)	
	Quarterly Bonus Amount	
Provider Roster Submission to Better Doctors	$500	For all provider groups delegated for credentialing and large group providers
Individual Provider attestation with Better Doctors	$50	For non-delegated providers and small practices who do not submit rosters

Program measure specifications

Asthma medication ratio (AMR)

The percentage of patients ages 5-64 with persistent asthma whose ratio of asthma controller medications to total asthma medications is 50% or greater during the program year.

Member Rewards

Members may earn reward dollars for consistent use of asthma controller medications. Mention this when speaking with the member. If not registered, direct member to **metroplusrewards.org**.

Numerator / Denominator

Numerator

The number of members who have a medication ratio of ≥0.50 during the program year

Denominator

Members ages 5-64 years who have persistent asthma during both the program year and the year prior

Exclusion criteria

- Emphysema
- COPD
- Obstructive Chronic Bronchitis
- Chronic respiratory conditions due to fumes or vapors
- Cystic Fibrosis
- Acute Respiratory Failure
- Hospice care during the program year
- Members who died during the program year

Asthma controller medications for compliance

- Antibody inhibitors: omalizumab
- Anti-interleukin-4: dupilumab
- Anti-interleukin-5: benralizumab, mepolizumab, reslizumab
- Inhaled steroid combinations: budesonide-formoterol, fluticasone-salmeterol, fluticasone-vilanterol, formoterol-mometasone
- Inhaled corticosteroids: beclomethasone, budesonide, ciclesonide, flunisolide, fluticasone, mometasone
- Leukotriene modifiers: montelukast, zafirlukast, zileuton
- Methylxanthines: theophylline

Codes for compliance

For a complete list of compliant/exclusion/medication codes, please visit:

metroplus.org/providers/hedis-qarr-materials

and download the **HEDIS/QARR–Code** sheet and go to the **P4P_Codes** tab.

Helpful tips to improve your performance

- Ensure your treatment of mild to severe asthma is aligned with the **GINA Guideline updates**. The recommendation is to replace traditionally used rescue/reliever inhaler medications such as Albuterol or short acting beta agonists with **ICS-LABA** inhaler medications to manage AND reduce the risk of exacerbations. Dosing increases are recommended for increased severity. For more information, go to: **Pocket Guide for Asthma Management and Prevention - Global Initiative for Asthma - GINA**.

ginasthma.org

- Start an asthma action plan with all members diagnosed with persistent asthma.
- Educate members on the importance and use of controller medications.
- Utilize support staff to conduct telephone visits and virtual check-ins on medication adherence.
- Reschedule “no-shows” immediately and make those appointments a priority.
- Exclusions should be documented in the member’s history and billed with the code listed in the MetroPlusHealth **HEDIS/QARR – Code** Sheet.

Breast cancer screening – ECDS (BCS-E)

The percentage of members ages 50–74 years who were recommended for routine breast cancer screening and had a screening mammogram for breast cancer.

Member Rewards

Members may earn reward dollars for completing a mammogram. Mention this when speaking with the member. If not registered, direct member to **metroplusrewards.org**.

Numerator / Denominator

Numerator	Member had one or more mammograms any time on or between October 1 two years before the program year and the end of the program year
Denominator	Members ages 50–74
Exclusion criteria	• Members who died during the program year • Members in hospice or using hospice services during the program year • Members who had a bilateral mastectomy or both right and left unilateral mastectomies • Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria (Gender Dysphoria Value Set) • Members 66 years of age with frailty and advanced illness • Members who received palliative care any time during the program year

Codes for compliance

For a complete list of compliant/exclusion/medication codes, please visit:

metroplus.org/providers/hedis-qarr-materials

and download the **HEDIS/QARR–Code** sheet and go to the **P4P_Codes** tab.

Helpful tips to improve your performance

- Educate the member on the importance of early breast cancer detection.
- Place the radiology order for mammography, or create standing orders, to better facilitate screening.
- Discuss common fears and misconceptions about breast cancer screening. Employ motivational interviewing techniques to combat screening hesitancy.
- For members with a history of bilateral mastectomy:
  - Submit diagnosis code Z90.13 on a claim in the program year.
- If the mammogram was completed elsewhere:
  - Update in the member history or health maintenance with the date of service in the program year.
- Help members schedule the screening. Conduct reminder calls to help them keep their scheduled screening.
- For measures reported using Electronic Clinical Data Systems, work with your assigned MetroPlusHealth Quality Coordinator to establish a data exchange process that supports measured performance. If you do not have an assigned Quality Coordinator, please reach out to **qmophedis4@metroplus.org**.

Cervical cancer screening – ECDS (CCS-E)

The percentage of members ages 21–64 years who were recommended for routine cervical cancer screening.

Member Rewards

Members may earn reward dollars for completing a pap smear or HPV co-testing. Mention this when speaking with the member. If not registered, direct member to **metroplusrewards.org**.

Numerator / Denominator

Numerator

The number of members recommended for routine cervical cancer screening who were screened for cervical cancer. Either of the following meets criteria:

- Members 21–64 years of age by the end of the program year who were recommended for routine cervical cancer screening and had cervical cytology during the program year or the 2 years prior to the program year
- Members 30–64 years of age by the end of the program year who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing during the program year or the 4 years prior to the program year, and who were 30 years or older on the test date

Denominator

The initial population (members 21-64 years of age recommended for routine cervical cancer screening), minus exclusions

Exclusion criteria

- Hysterectomy with no residual cervix
- Members with sex assigned at birth of male at any time during patients' history
- Members in hospice or using hospice services during the program year
- Members who received palliative care any time during the program year
- Members who died during the program year

Codes for compliance

For a complete list of compliant/exclusion/medication codes, please visit:

metroplus.org/providers/hedis-qarr-materials

and download the **HEDIS/QARR–Code** sheet and go to the **P4P_Codes** tab.

Helpful tips to improve your performance

- Utilize sick and well-visits to conduct Pap smear.
- Refer members to an OB/Gyn if applicable.
- Contact unengaged members and offer to help schedule an appointment. Conduct reminder calls to help them keep their scheduled appointment.
- Discuss common fears and misconceptions about Pap smears and employ motivational interviewing techniques to combat screening hesitancy.
- Reschedule "no-shows" immediately. Prioritize those appointments and ensure they occur on or before 12/31 of the program year.
- For members with a history of cervix removal:
  - Submit diagnosis code Z90.710 or Z90.712 on a claim in the program year.
- If the Pap smear was completed elsewhere:
  - Update in the member history or health maintenance with the date of service in the program year.
- For measures reported using Electronic Clinical Data Systems, work with your assigned MetroPlusHealth Quality Coordinator to establish a data exchange process that supports measured performance. If you do not have an assigned Quality Coordinator, please reach out to **qmophedis4@metroplus.org**.

Chlamydia screening in women (CHL)

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 program year.

Member Rewards

Members may earn reward dollars for completing a chlamydia screening. Mention this when speaking with the member. If not registered, direct member to **metroplusrewards.org**.

Numerator / Denominator

Numerator	Members who had at least one chlamydia test during the program year
Denominator	Members 16–24 years of age who had a medical or pharmacy claim/encounter that indicated sexual activity (contraception, pregnancy tests, etc.) as of December 31 of the program year
Exclusion criteria	• A prescription for isotretinoin (retinoid) on the day of the pregnancy test or 6 days after • An X-ray on the same day through 6 days after the pregnancy test • Members who died during the program year • Members in hospice or using hospice services during the program year

Codes for compliance

For a complete list of compliant/exclusion/medication codes, please visit:

metroplus.org/providers/hedis-qarr-materials

and download the **HEDIS/QARR–Code** sheet and go to the **P4P_Codes** tab.

Helpful tips to improve your performance

- Utilize any visit type to conduct chlamydia screening.
- Consider placing standing lab orders that can be completed outside of an office visit.
- PCPs can conduct a urine PCR/NAAT test to satisfy measure compliance.
- Include chlamydia screening when conducting pregnancy test and/or screenings for other STIs (for example: HIV, syphilis).
- Consider making chlamydia screening a standard lab for members on birth control.
- Discuss common fears and misconceptions about STI screening and employ motivational interviewing techniques to combat screening hesitancy.
- Reschedule “no-shows” immediately and make those appointments a priority.

Colorectal cancer screening – ECDS (COL-E)

The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.

Member Rewards

Members may earn reward dollars for completing colon cancer screening. Mention this when speaking with the member. If not registered, direct member to **metroplusrewards.org**.

Numerator / Denominator

Numerator

- Members with one or more screenings for colorectal cancer. Any of the following meet the criteria:
  - Fecal occult blood test (FOBT) every year, OR
  - Flexible sigmoidoscopy during the program year or 4 years prior, OR
  - Colonoscopy during the program year or 9 years prior, OR
  - Stool DNA with FIT test during the program year or 2 years prior, OR
  - CT Colonography during the program year or 4 years prior

Denominator

Members between the ages of 45-75 during the program year

Exclusion criteria

- Colorectal cancer
- Total colectomy
- Palliative care
- Members who died during the program year
- Members in hospice or using hospice services during the program year

Codes for compliance

For a complete list of compliant/exclusion/medication codes, please visit:

metroplus.org/providers/hedis-qarr-materials

and download the **HEDIS/QARR–Code** sheet and go to the **P4P_Codes** tab.

Helpful tips to improve your performance

- Educate and stress the importance of screening for colon cancer AND offer less invasive options, like FOBT or FIT DNA for members refusing a colonoscopy. Place the requested order.
- Educate the member on the importance of early detection. Stress the age recommendations for screening for members 45–49.
- Refer members to a GI specialist during both sick and well-visits if screening is not done. Help them schedule the appointment or screening. Conduct reminder calls to help them keep their scheduled appointments.
- For members with a history of colon cancer:
  - Submit diagnosis code C18.0-C18.9 on a claim in the program year.
- If the colon cancer screening was completed elsewhere:
  - Update in the member history or health maintenance with the date of service in the program year.
- For measures reported using Electronic Clinical Data Systems, work with your assigned MetroPlusHealth Quality Coordinator to establish a data exchange process that supports measured performance. If you do not have an assigned Quality Coordinator, please reach out to **qmophedis4@metroplus.org**.

Eye exam for patients with diabetes (EED)

The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

Numerator / Denominator

Numerator

- A retinal exam and/or detailed documentation of one of the following:
  - A dilated or retinal eye exam by an eye care professional (ophthalmologist or optometrist) during the program year
  - A negative eye exam for retinopathy the year prior to the program year
- A bilateral eye enucleation during member's history through the program year

Denominator

Members 18–75 years of age with diabetes (types 1 and 2). Members are identified as having diabetes when they were dispensed diabetes classified medication and have a diabetes diagnosis during the program year or the year prior

Exclusion criteria

- Members in hospice or using hospice services during the program year
- Members who received palliative care any time during the program year
- Members ages 66+ as of 12/31 who had institutional SNP or are living long-term in an institution during the program year
- Members ages 66+ as of 12/31 with frailty and advanced illness during or prior to the program year
- Members taking dementia medication during or prior to the program year
- Members who died during the program year

Telehealth

Telehealth cannot be used for compliance. Please note that teleretinal* services are compliant.

Codes for compliance

For a complete list of compliant/exclusion/medication codes, please visit:

metroplus.org/providers/hedis-qarr-materials

and download the **HEDIS/QARR–Code** sheet and go to the **P4P_Codes** tab.

Helpful tips to improve your performance

- Document the details of the exam, including diagnosis and results of eye exam.
- Recommend and assist in scheduling other important screenings like an annual kidney, foot and dental exams.
- *Consider using a fundus camera in primary care setting, with results read by an eye care specialist. If in use, consider using support staff to take photos.
- Call unengaged members and offer to help schedule an appointment. Conduct reminder calls to help them keep their scheduled appointment.
- Reschedule "no-shows" immediately and make those appointments a priority to keep the member "on schedule."
- Educate patient and/or caregiver about the importance of diabetic eye exams regardless of A1c control.
- Refer the patient to a MetroPlusHealth participating eye care provider (Ophthalmologist or Optometrist) if they have not completed an annual eye exam. Help schedule the needed appointment.
- Encourage the patient to visit the following website to learn more about diabetes and resources available to them at:

metroplus.org/members/health-information/diabetes

Kidney health evaluation for patients with diabetes (KED)

The percentage of members 18–85 years of age with diabetes (types 1 and 2) who received a kidney health evaluation. Both an estimated glomerular filtration rate (eGFR) AND a urine albumin-creatinine ratio (uACR) must be completed during the program year.

Numerator / Denominator

Numerator

Members who received both an eGFR and a uACR during the program year on the same or different dates of service:

- At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set)
- At least one uACR identified by either of the following:
  - Both a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) and a urine creatinine test (Urine Creatinine Lab Test Value Set) with service dates 4 days or less apart in the program year
  - A uACR test (Urine Albumin Creatinine Ratio Lab Test Value Set)

Denominator

Members 18–85 years of age with diabetes (types 1 and 2). Members are identified as having diabetes when they were dispensed diabetes classified medication and have a diabetes diagnosis during the program year or the year prior

Exclusion criteria

- Members diagnosed with ESRD during or before the program year
- Members who had dialysis during or before the program year
- Members in hospice or using hospice services during the program year
- Members who received palliative care any time during the program year
- Members ages 66+ as of 12/31 who had institutional SNP or were living long-term in an institution during the program year
- Members ages 60-81 as of 12/31 with frailty and advanced illness during or prior to the program year
- Members taking dementia medication during or prior to the program year
- Members who died during the program year

Codes for compliance

For a complete list of compliant/exclusion/medication codes, please visit:

metroplus.org/providers/hedis-qarr-materials

and download the **HEDIS/QARR–Code** sheet and go to the **P4P_Codes** tab.

Helpful tips to improve your performance

- Document all the details of the exam, including diagnosis and results of the kidney exam.
- Order urine albumin and urine creatinine together. Consider ordering for recently-seen members without having them come back in.
- Urine Protein Creatinine Ration does not count whereas Urine Albumin Creatine does comply as part of the KED measure.
- Call unengaged members and offer to help schedule an appointment. Conduct reminder calls to help them keep their scheduled appointment.
- Recommend and help schedule other important screenings like annual retinal, foot and dental exams.
- Reschedule “no-shows” immediately and make those appointments a priority.
- Educate patient and/or caregiver about the risks of uncontrolled diabetes and the importance of a healthy lifestyle.
- Prescribe a statin for your patients with diabetes unless contraindicated.
- Encourage the patient to visit the following website to learn more about diabetes and resources available to them at:

metroplus.org/members/health-information/diabetes

Non-User (NUS)

The percentage of members assigned to a primary care physician for 3 or more months who have not engaged in care for medical services during the program year.

Numerator / Denominator

Numerator

- A visit within the program year with a medical professional that has been billed to the Plan
- Qualifying visits are any medical services performed and appropriately billed to the Plan, including telehealth visits with an audio and visual component
- Pharmacy interactions do not qualify on their own. There must be a correlating medical service billed for the prescription dispensed
- Medical record or EHR documentation will not be considered for compliance. All compliance triggers are via appropriately billed and accepted claims

Denominator Members assigned to a primary care physician's panel for 3 or more months during the program year

Telehealth

Telehealth can be used for compliance.

Helpful tips to improve your performance

- Engage non-user members immediately at the start of the program year.
- Target members with telehealth or annual wellness calls to complete an assessment of current health status.
- Call members and offer to help schedule an appointment. Conduct reminder calls to help them keep their scheduled appointment.
- Reschedule "no-shows" immediately. Prioritize those appointments and ensure they occur on or before 12/31 of the program year.
- For additional questions, contact: **qmophedis4@metroplus.org**.

Well-child visits: 0–30 months (W30)

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

1. **Well-Child Visits in the First 15 Months. Children who turned 15 months old during the program year: Six or more well-child visits.**
2. **Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the program year: Two or more well-child visits.**

Member Rewards

The Parent/Guardian may earn reward dollars when their child completes all well-child visits. Mention this when speaking with the Parent/Guardian. If not registered, direct Parent/Guardian to **metroplusrewards.org**.

Numerator / Denominator

Numerator

- Rate 1: Six or more well-child visits on different dates of service on or before the 15-month birthday
- Rate 2: Two or more well-child visits on different dates of services between the child's 15-month birthday plus 1 day and the 30-month birthday

Denominator

- Rate 1: Eligible population – children who turned 15 months old during the program year
- Rate 2: Eligible population – children who turned 30 months old during the program year

Exclusion criteria

- Members in hospice or using hospice services during the program year
- Members who died during the program year

Telehealth

Telehealth visits are applicable, but a well-visit code must be included on the claim.

Codes for compliance

For a complete list of compliant/exclusion/medication codes, please visit:

metroplus.org/providers/hedis-qarr-materials

and download the **HEDIS/QARR–Code** sheet and go to the **P4P_Codes** tab.

Helpful tips to improve your performance

- The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.
- The only documentation requirement is that a well-visit occurred.
- Pre-schedule the member's next well-visit at the end of their latest visit.
- Conduct and code for a well-visit during any visit (for example, sick visits).
- Be sure to schedule consecutive well-visits at least 14 days apart.
- Utilize NP or PA resources if available to complete well-visits.
- Call the parent/guardian and offer to help schedule an appointment for their child to complete a well-visit and immunizations. Conduct reminder calls to help them keep their scheduled appointment.
- Reschedule "no shows" immediately and make those appointments a priority to keep the member "on schedule."

Child-adolescent well-visits (WCV)

The percentage of 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 program year.

Member Rewards

The Parent/Guardian may earn reward dollars when their child completes their annual well child-adolescent visit. Mention this when speaking with the Parent/Guardian. If not registered, direct Parent/Guardian to **metroplusrewards.org**. Adolescents 18 years and over can register for their own reward dollars card.

Numerator / Denominator

Numerator	One or more well-visits during the program year
Denominator	Members between the ages of 3–21 years as of December 31 of the program year
Exclusion criteria	• Members in hospice or using hospice services during the program year • Members who died during the program year

Telehealth

Telehealth visits are applicable, but a well-visit code must be included on the claim.

Codes for compliance

For a complete list of compliant/exclusion/medication codes, please visit:

metroplus.org/providers/hedis-qarr-materials

and download the **HEDIS/QARR–Code** sheet and go to the **P4P_Codes** tab.

Helpful tips to improve your performance

- The well-visit must occur with a PCP or an OB/GYN. However, the provider does not have to be the provider assigned to the member.
- The only documentation needed is that a well-visit occurred.
- Pre-schedule the member's next well-visit at the end of their latest visit.
- Conduct and code for a well-visit during any visit (e.g., sick visits).
- Well-visits can occur with an MD, NP, PA or OB/GYN.
- Reschedule "no-shows" immediately. Prioritize those appointments and ensure they occur on or before 12/31 of the program year.
- Call the parent/guardian and offer to help schedule an appointment for their child to complete a well-visit and immunizations. Conduct reminder calls to help them keep their scheduled appointment.

New member PCP visit within 60 days (NMV)

Members (any age) newly enrolled during the program year should have a primary care visit within 60 days of enrollment to the plan.

Member Rewards

Members may earn reward dollars for completing a primary care visit within 90 days of enrollment. Mention this when speaking with the member. If not registered, direct member to **metroplusrewards.org**.

Numerator / Denominator

Numerator	One or more primary care visits within 60 days of the member's effective date of enrollment in the Plan during the program year
Denominator	Members any age newly enrolled to MetroPlusHealth during the program year. 'Newly Enrolled' is defined as a member that has NOT been a MetroPlusHealth member in any product line in the prior 12 months to their enrollment during the program year
Exclusion criteria	Members must not have had a visit with a MetroPlusHealth PCP in the prior 12 months to their enrollment in the Plan

Telehealth

Telehealth can be used for compliance if appropriate CPT codes listed below are submitted on a claim.

Codes for compliance

Procedure Codes used to identify primary care visits: 99381 – 99397 or 99202 – 99205 or 99211 – 99215

Providers will be paid their contracted visit rate AND receive an incentive award if the visit occurs within 60 days of enrollment.

Helpful tips to improve your performance

- Set aside scheduling slots for new members to ensure visits are scheduled and fulfilled quickly.
- Call members and offer to help schedule an appointment. Conduct reminder calls to help them keep their scheduled appointment.
- Reschedule "no-shows" immediately. Prioritize those appointments and ensure they occur within 60 days of the enrollment effective date.
- Providers should use the MetroPlusHealth **Member Roster** to identify members who meet eligibility criteria for this measure. Look for the "New Member" column on your PCP roster located in the

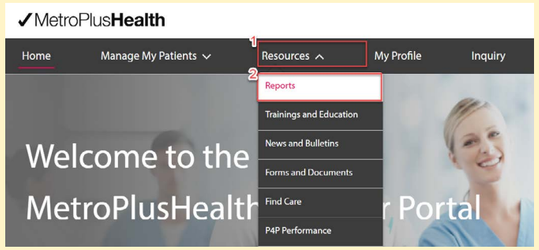
MetroPlusHealth Provider Portal

- When the "New Member" column is flagged with a 'Yes' on your **Member Roster**, the member is eligible and still has time left within the 60-day timeframe to meet measure compliance.
- The **Member Roster** should be downloaded monthly to ensure you have enough time to outreach, schedule and complete visits within 60 days for newly enrolled members.
- Find the Member Roster in the MetroPlusHealth Provider Portal.
- If you are not registered:
  Contact Provider Support at **800.303.9626** for assistance with registration to the

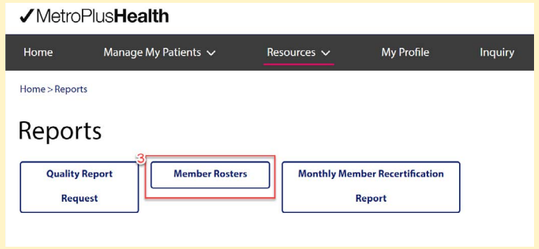
MetroPlusHealth Provider Portal

- If you are already registered, log into the portal: The following screenshots are provided as reference.

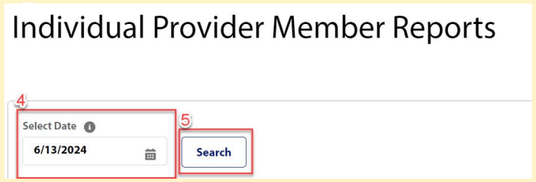
1. Go to **Resources**
2. Select **Reports**



3. Click the **Member Rosters** button



4. Select the **current date** (default) in the **Select Date** field
5. Click the **Search** button



6. See the **New Member** column in your report

Social Needs screening (SNS)

Members (18+) who screen positive for Food and/or Housing and/or Transportation insecurities should have a follow-up intervention conducted within 30 days of the positive screening.

Numerator / Denominator

Numerator	Members who screen positive and have a follow-up intervention (i.e., assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision, or referral) within 30 days of the positive screening
Denominator	Members aged 18 years or older as of December 31 of the program year who screened positive for Food and/or Housing and/or Transportation insecurities
Exclusion criteria	• Members in hospice or using hospice services during the program year • Members who died during the program year • Members who are in an I-SNP or living long-term in an institution during the program year

Telehealth

Telehealth can be used for compliance if appropriate codes listed below are submitted on a claim.

Codes for compliance

Diagnosis Codes used to identify positive screening visits include:
Food: Z59.41, Housing: Z59.819 or Z59.89, Transportation: Z59.82

Procedure Codes used to identify follow up interventions for all 3 SNS insecurities include:
Health Behavior Assessment and Intervention (HBAI) services: 96156, Health Risk Assessment (HRA): 96160 or 96161

Procedure Codes used to identify follow-up interventions for food insecurity only include:
Medical nutrition therapy: 97802-97804, Home delivered prepared meals: S5170, Nutritional counseling, Dietitian visit: S9470.

All other follow-up interventions **must be shared** through file feeds or medical records.

Helpful tips to improve your performance

- Screening is needed to qualify a member for the measure. However, members can only qualify for the P4P program if they have a positive screening for either food, housing or transportation insecurity.
- Follow-up interventions may occur on the same date of screening. Any of the following categories are applicable: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision, or referral.
- For referrals, providing information on resources like FindHelp and UniteUs meets measure compliance. Consider making these referrals on the same day as the positive screen. Document in the visit note all verbal referrals or printed collateral that is shared with the member.
- You can also refer to a Social Worker, Case Manager, Peer Support, Dietitian, Meals on Wheels, etc. Be sure to clearly document the referral.
- MetroPlusHealth's Social Determinants of Health Resources may be used to refer members that screen positive for services that may assist. If documented in your EMR, this would count as a follow-up. For a full breakdown of resources, please visit:

Social Determinants of Health Resources

- You must use validated screening questions/ tools for this screen. Examples include:

Health Leads Screening Panel

AHC HRSN

PRAPARE

- For measures reported using Electronic Clinical Data Systems, work with your assigned MetroPlusHealth Quality Coordinator to establish a data exchange process that supports measured performance. If you do not have an assigned Quality Coordinator, please reach out to **qmophedis4@metroplus.org**.

STI screening (STI) – chlamydia, gonorrhea, and syphilis HIV SNP only

Percentage of HIV-positive members enrolled in HIV SNP who are screened annually for all three STIs: chlamydia, gonorrhea, and syphilis.

Member Rewards

Members may earn reward dollars for completing a chlamydia screening. Mention this when speaking with the member. If not registered, direct member to **metroplusrewards.org**.

Numerator / Denominator

Chlamydia/Gonorrhea Testing

Numerator HIV-positive members who were screened annually for chlamydia and gonorrhea

Denominator HIV-positive members enrolled in HIV SNP with at least 1 visit in the program year

Syphilis Testing

Numerator HIV-positive members who were screened annually for syphilis

Denominator HIV-positive members enrolled in HIV SNP with at least 1 visit in the program year

Helpful tips to improve your performance

- Utilize any type of visit to conduct STI screening. Place the order, or create standing orders, to better facilitate.
- Include STI screening when you conduct a pregnancy test and/or other routine lab testing.
- PCPs can conduct a urine PCR/NAAT test to satisfy STI screening for chlamydia/gonorrhea.
- Consider placing standing lab orders that can be completed outside of an office visit.
- Per NYS clinical guidelines, patients who do not report being sexually active should still have STI screening.
- Call members and offer to help schedule an appointment. Conduct reminder calls to help them keep their scheduled appointments.
- Reschedule “no-shows” immediately and make those appointments a priority.

Codes for compliance

Chlamydia/Gonorrhea Testing

(both chlamydia AND gonorrhea codes are needed for compliance with this incentive)

For chlamydia screening (any of the following codes):

87270 - Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis

87320 - Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Chlamydia trachomatis

87490 - Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique

87491 - Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique

87492 - Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification

87810 - Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; Chlamydia trachomatis

For gonorrhea screening (any of the following codes):

87590 - Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique

87591 - Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique

87592 - Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification

87850 - Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; Neisseria gonorrhoeae

Syphilis Screening

86592 - Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART)

86593 - Syphilis test, non-treponemal antibody; quantitative

86780 - Antibody; Treponema pallidum

Adult immunization status, influenza – ECDS (AIS-E) HIV SNP only

The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus, and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal infections.

Member Rewards

Members may earn reward dollars for receiving a flu shot. Mention this when speaking with the member. If not registered, direct member to **metroplusrewards.org**.

Numerator / Denominator

Numerator
Members who received an influenza vaccine on or between July 1 of the year prior to the program year and June 30 of the program year, or members with anaphylaxis due to the influenza vaccine any time before or during the program year

Denominator
Members 19 years of age and older

Exclusion criteria
- Members who died during the program year
- Members in hospice or using hospice services during the program year

Codes for compliance

For a complete list of compliant/exclusion/medication codes, please visit:

metroplus.org/providers/hedis-qarr-materials

and download the **HEDIS/QARR–Code** sheet and go to the **P4P_Codes** tab.

Helpful tips to improve your performance

- Include date of administration or anaphylaxis/encephalitis.
- Utilize well-visits to administer flu shots and ensure member is up to date. Bill for the vaccine accordingly.
- Call members and offer to help schedule an appointment. Conduct reminder calls to help them keep their scheduled appointments.
- Reschedule “no-shows” immediately and make those appointments a priority.
- Employ motivational interviewing techniques to actively combat vaccine hesitancy.
- Direct members to a nearby Pharmacy for their flu vaccine.
- Submit immunizations to the Citywide Immunization Registry (CIR) the same day they are given.
- For measures reported using Electronic Clinical Data Systems, work with your assigned MetroPlusHealth Quality Coordinator to establish a data exchange process that supports measured performance. If you do not have an assigned Quality Coordinator, please reach out to **qmophedis4@metroplus.org**.

Viral load suppression (VLS)

HIV SNP only

HIV SNP members confirmed HIV-positive should have an HIV viral load less than 200 copies/mL at last HIV viral load test during the program year.

Member Rewards

Members may earn reward dollars for completing HIV primary care visit(s) in the first and second halves of the year. Mention this when speaking with the member. If not registered, direct member to **metroplusrewards.org**.

Numerator / Denominator

Numerator	The number of HIV SNP enrollees in the denominator with a HIV viral load less than 200 copies/mL for the last HIV viral load test during the program year
Denominator	Members 2 years of age and older

Codes for compliance

Not applicable. Lab results are required to capture compliance. Participating providers are **required** to share viral load results electronically at minimum quarterly to earn this incentive.

Helpful tips to improve your performance

- Members living with HIV should have a viral load test and follow-up appointment at least every six months (twice in calendar year).
- Members with unsuppressed viral loads should have more frequent follow-up visits with their HIV care provider, at least every 3 months.
- Explain the importance of viral load testing: it can identify a possible need to change treatment.
- Stress that reaching viral load suppression can help members live healthier, longer lives and reduce the risk of transmitting the virus to others (Undetectable = Untransmittable).
- Consider prescribing 90-day refills for HIV medications when applicable.
- Call members and offer to help schedule an appointment. Conduct reminder calls to help them keep their scheduled appointments.
- Reschedule “no shows” immediately and make those appointments a priority.

Access, availability and accuracy

The percentage of providers that have more than 200 members in February 2024 who are surveyed and pass MetroPlusHealth Access & Availability surveys with at least 75% and participate quarterly with Better Doctors/Quest Analytics to support data accuracy standards.

Numerator / Denominator

Access & Availability

Numerator The number of surveys for Non-Urgent Sick, Emergency and Urgent appointment availability that meet standards during the program year

Denominator Providers with > 200 members across Medicaid, CHP, HIV SNP, HARP and Essential Plan as of February 2024 and surveyed for Non-Urgent Sick, Emergency and Urgent appointment availability

Additional Information

- Providers earn $3 PMPM when you achieve an 80% pass rate or $2 PMPM for a 75% pass rate when surveyed for Non-Urgent Sick, Emergency and Urgent appointment availability.
- Providers earn up to $500 in bonus payments for each quarter of 2024 you submit your provider roster to Better Doctors/Quest Analytics.
  - Group Roster Submission: $500
  - Individual Provider Attestation to no changes: $50

Helpful tips to improve your performance:

- Better Doctors/Quest Analytics will contact you on MetroPlusHealth's behalf. Participate when they do.
- Ensure your office staff are aware of the following MetroPlusHealth appointment availability time frame standards. Appointment Types with the (P4P) indicator in the grid below will be used to measure Access and Availability in the program.

Access and availability standards

MetroPlusHealth members must secure appointments within the following guidelines:

Provider Type	Appointment type	Availability timeframe	Incentive
PCP	Emergency care	Immediately upon presentation	✓
PCP	Urgent medical	Within 24 hours of request	✓
PCP	Non-urgent "sick" visit	Within 48 to 72 hours of request, as clinically indicated	✓
PCP	Routine non-urgent, preventive or well childcare	Within 4 weeks of request	✗
PCP	Adult baseline or routine physical	Within 12 weeks of enrollment	✗
Pediatrics	Urgent	Within 24 hours of request	✓
Pediatrics	Routine wellchild	Within 4 weeks of request	✗
Pediatrics	Non-urgent sick	Within 48 to 72 hours of request	✓
Pediatrics	Newborn	Within 48 hours of request	✗

Questions? We're here to help.

Provider Support

Call Provider Services **1.800.303.9626**

Monday–Friday, 8 am–6 pm

Quality Incentive Program & Specifications Support

Email Quality Management **qmophedis4@metroplus.org**

Metro Plus Health

PRV 24.066 6/24