

2026

Pay for Performance Program



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Questions? We're here to help. 38

¹ Electronic Clinical Data Systems (ECDS) measures require structured electronic data that meet HEDIS specifications, from sources like electronic health records, registries, health information exchanges, and claims systems. Data must follow standard layouts, be auditable, and accessible to providers for quality reporting.

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.

- 200 or more to obtain 100% of the program earnings.

Minimum Panel Size¹

- 150–199 to earn 50% of the program earnings (*Access, Availability & Accuracy measures are not applicable*).

Measure Minimum¹

Each measure must have 20 or more members in the denominator to qualify for incentive.

Benchmark Tiers¹

2025 New York State Medicaid benchmarks will be used to determine tier amount earned.

Provider Attribution

Provider overall and measure panels are based on PCP assignment on December 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pursuant to the provider contract, payment under the P4P program is within MetroPlusHealth's sole discretion and may be withdrawn or discontinued or capped at any time for any reason, including reductions in state or federal funding or payments. MetroPlusHealth also reserves the right in its sole discretion to implement modifications to this P4P program for providers on an individual basis as appropriate. 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 HIV SNP PCP specific rewards do not have benchmark tiers or panel/measure minimum requirements.





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.



How payment is calculated and distributed

MetroPlusHealth will pay incentives once a year in the fall after the program year or quarterly. Roster submission 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
Breast Cancer Screening	\$40	\$60	\$80	Benchmark Tier
Cervical Cancer Screening	\$40	\$60	\$80	Benchmark Tier
Chlamydia Screening	\$20	\$30	\$50	Benchmark Tier
Colorectal Screening	\$40	\$60	\$80	Benchmark Tier
Diabetes Care Eye Exam	\$40	\$60	\$80	Benchmark Tier
Diabetes Kidney Health Evaluation	\$20	\$30	\$50	Benchmark Tier
Well-child 15 months – 6 visits	\$75	\$125	\$200	Benchmark Tier
Well-child 30 months – 2 visits	\$50	\$100	\$150	Benchmark Tier
Well-child and Adolescent Visit	\$10	\$25	\$40	Benchmark Tier
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 and 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 panel size 150–199 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	\$80

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	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 \$80)/2	\$4,000



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 panel size 150–199 will receive 50% of earnings in the program. See the example below:

Measure	Award Amount (\$)
Per-Member	
Chlamydia/Gonorrhea Testing	\$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	1,000	\$50	$1,000 \times \$50$	\$50,000
B	162	50	\$50	$(50 \times \$50)/2$	\$1,250
C	250	26	\$50	$26 \times \$50$	\$1,300
D	150	100	\$50	$(100 \times \$50)/2$	\$2,500



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 from the Access and Availability Survey.



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	\$500	For all provider groups delegated for credentialing and large group providers
Individual Provider Attestation	\$50	For non-delegated providers and small practices who do not submit rosters



Program measure specifications

Breast cancer screening – ECDS (BCS-E)

The percentage of members ages 40–74 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 40–74

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 ages 66+ as of December 31 who had institutional SNP or are living long-term in an institution during the program year
- Members ages 66+ as of December 31 with frailty and advanced illness during or prior to program year. Taking dementia medication may be considered as an indicator of 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 code Z90.13 was submitted historically for a member, the code will be carried over to this 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

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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 December 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 code Z90.710 or Z90.712 was submitted historically for a member, the code will be carried over to this 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 (CHL)

The percentage of persons 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the program year.

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	<ul style="list-style-type: none">• 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• Members with sex assigned at birth of male at any time during patient's history





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	<ul style="list-style-type: none">Members with one or more screenings for colorectal cancer. Any of the following meet the criteria:<ul style="list-style-type: none">○ 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	<ul style="list-style-type: none">Colorectal cancer – Diagnosis of malignant colorectal cancer and/or history of colorectal cancerTotal colectomyPalliative careMembers who died during the program yearMembers in hospice or using hospice services during the program yearMembers ages 66+ as of December 31 who had institutional SNP or are living long-term in an institution during the program yearMembers ages 66+ as of December 31 with frailty and advanced illness during or prior to program year. Taking dementia medication may be considered as an indicator of advanced illness.





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 code C18.0-C18.9 was submitted historically for a member, the code will be carried over to this 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	<ul style="list-style-type: none">• A retinal exam and/or detailed documentation of one of the following:<ul style="list-style-type: none">◦ 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
Denominator	Members 18–75 years of age with diabetes (types 1 and 2). Members are identified as having diabetes by two diagnoses of diabetes on different dates of service, or a diagnosis of diabetes and dispensed diabetes classified medication during the program year or the year prior.
Exclusion criteria	<ul style="list-style-type: none">• 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 December 31 who had institutional SNP or are living long-term in an institution during the program year• Members ages 66+ as of December 31 with frailty and advanced illness during or prior to program year. Taking dementia medication may be considered as an indicator of advanced illness.• Members who died during the program year• A bilateral eye enucleation during member's history through 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 website below to learn more about diabetes and resources available to them.
- Submit claims and encounter data promptly, as these are the primary methods used to capture completed diabetic eye exams.

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: <ul style="list-style-type: none">• At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set)• At least one uACR identified by either of the following:<ul style="list-style-type: none">◦ 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 by two diagnoses of diabetes on different dates of service, or a diagnosis of diabetes and dispensed diabetes classified medication during the program year or the year prior.
Exclusion criteria	<ul style="list-style-type: none">• 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 December 31 who had institutional SNP or were living long-term in an institution during the program year• Members ages 66-80 as of December 31 with frailty and advanced illness during or prior to program year. Taking dementia medication may be considered as an indicator of advanced illness.• Members who died during the program year• Members 81+ as of December 31 with frailty 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:

metroplus.org/members/health-information/diabetes



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 15–30 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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• Members in hospice or using hospice services during the program year• Members who died during the program year





Telehealth

Telehealth visits are NOT applicable.



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 NOT applicable.



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 December 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.



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

Percentage of Medicaid HIV SNP enrollees that have had an STI screening for Chlamydia, Gonorrhea, or Syphilis during measurement 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

Chlamydia/Gonorrhea Testing

Numerator Medicaid HIV SNP enrollees ages 16 to 45 who were screened annually for Chlamydia and Gonorrhea

Denominator Medicaid HIV SNP enrollees ages 16 to 45

Syphilis Testing

Numerator Medicaid HIV SNP enrollees ages 20 to 45 who were screened annually for Syphilis

Denominator Medicaid HIV SNP enrollees ages 20 to 45

Exclusion criteria Members in hospice or using hospice services during 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

Value Set		
Value_Set_Name	Code	Code_System
NYS Chlamydia Screen	86631	CPT
NYS Chlamydia Screen	86632	CPT
NYS Chlamydia Screen	87110	CPT
NYS Chlamydia Screen	87270	CPT
NYS Chlamydia Screen	87320	CPT
NYS Chlamydia Screen	87490	CPT
NYS Chlamydia Screen	87491	CPT
NYS Chlamydia Screen	87492	CPT
NYS Chlamydia Screen	87810	CPT
NYS Chlamydia Screen	87800	CPT
NYS Chlamydia Screen	3511F	CPT
NYS Chlamydia Screen	0353U	CPT
NYS Gonorrhea Screen	87590	CPT
NYS Gonorrhea Screen	87591	CPT
NYS Gonorrhea Screen	87592	CPT
NYS Gonorrhea Screen	87850	CPT
NYS Gonorrhea Screen	87800	CPT
NYS Gonorrhea Screen	3511F	CPT
NYS Gonorrhea Screen	0353U	CPT
NYS Syphilis Screen	86348	CPT
NYS Syphilis Screen	86410	CPT
NYS Syphilis Screen	86592	CPT
NYS Syphilis Screen	86593	CPT
NYS Syphilis Screen	87285	CPT
NYS Syphilis Screen	0065U	CPT
NYS Syphilis Screen	0210U	CPT
NYS Syphilis Screen	80081	CPT
NYS Syphilis Screen	3512F	CPT
NYS Syphilis Screen	86781	CPT
NYS Syphilis Screen	86780	CPT



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.



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 living with HIV





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 a 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 2026 who are surveyed and pass MetroPlusHealth Access & Availability surveys with at least 75% and participate quarterly with our program to support data accuracy standards.

Numerator / Denominator

Access and 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 2026 and surveyed for Non-Urgent Sick, Emergency, and Urgent appointment availability

Additional Information

- Providers earn \$3 PMPM when you achieve an 80% annual pass rate or \$2 PMPM for a 75% annual 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 2026 you submit your roster of demographic information and attest to the accuracy of it.
 - Group Roster Submission: \$500
 - Individual Provider Attestation to no changes: \$50 (up to \$500 per group)



Helpful tips to improve your performance:

- A business partner or MetroPlusHealth will contact you by email or phone. 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.

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.



Provider Support

Call Provider Services **800.303.9626**

Monday – Friday, 8am – 6pm



Quality Incentive Program and Specifications Support

Email Quality Management qmophedis4@metroplus.org



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