PerformPlus® Total Cost of Care — Primary Care Providers

Improving quality care and health outcomes

January 2024

www.amerihealthcaritasnc.com

AmeriHealth Caritas™
North Carolina

Dear Primary Care Provider:

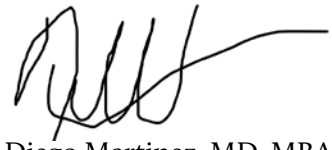
Thank you for participating in the AmeriHealth Caritas North Carolina's (ACNC's) Category 3 Alternative Payment Model (APM) program.

The PerformPlus Total Cost of Care (TCOC) program is specifically designed for our primary care providers (PCPs). The program offers incentives for delivering high-quality and cost-effective care to your patients, while also submitting timely key health data to the health plan so we can keep track of member outcomes.

ACNC is excited to provide this enhanced incentive program. We offer a variety of resources, including provider tools and monthly performance reports, as well as ongoing collaboration to assist you in meeting your 2024 goals.

Thank you for your continued participation in our network and your commitment to our members. If you have any questions, please contact your Provider Network Account Executive or ACNC Provider Services at **1-888-738-0004**.

Sincerely,



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Market Chief Medical Officer

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Program overview

The PerformPlus TCOC program is a program that provides an opportunity to receive incentives developed by ACNC for participating PCPs.

The TCOC is intended to be a fair and open system that provides incentives for high-quality and cost-effective care, member service and convenience, and submission of accurate and complete health data. Quality performance and efficiency are the most important determinants of the additional compensation. As new, meaningful measures are developed and introduced, the quality indicators contained in the TCOC will be refined. ACNC reserves the right to make changes to this program at any time and will provide written notification of any changes.

Total Cost of Care participation

The TCOC is intended to be a program that provides financial incentives beyond a PCP practice's base reimbursement. TCOC performance and associated incentive payments are calculated at the federal tax identification number (TIN) level — not per individual provider or group.

Eligible providers include those with:

- TINs of average panel sizes of 50 or more attributed ACNC members during the measurement period*
- TINs of AMH tier 2 or 3 designation

* Members who reside in skilled nursing facilities or who are dual-eligible members are not included in the quantified results for the TCOC program.

Ineligible providers include those with:

- TINs of average panel sizes of less than 50 ACNC attributed members during the measurement period
- TINs of AMH tier 1 or no AMH tier designation

Certain PerformPlus Total Cost of Care program components can only be measured effectively for PCP offices whose panels averaged 50 or more members.

A quality incentive payment may be paid in addition to a practice's base compensation.

Program specifications

The TCOC is designed to reward higher performance by practices that meet quality and cost benchmarks by delivering quality health care and reducing unnecessary costs for our attributed members. The incentive payment is based on a total cost of care risk-adjusted shared savings pool. This shared savings pool is available to practices whose attributed population demonstrates efficient use of services. Efficient use of services is defined as having an actual medical and pharmacy spend that is less than the expected medical and pharmacy spend in the measurement year, as determined using the 3M Clinical Risk Groups (CRG) methodology.

Efficient use of services calculation

The efficient use of services calculation leverages the 3M CRG platform to determine the total expected medical and pharmacy cost for all the members attributed to the practice. The expected medical and pharmacy cost for each individual member is the average of the cost observed for all members within each clinical risk group. These calculations are adjusted to remove outlier patients with excessive medical or pharmacy costs from consideration. Each member is assigned to a CRG based on the presence of disease and their corresponding severity level(s), as well as additional information that informs their clinical risk. CRGs can provide the basis for a comparative understanding of severity, treatment, best practice patterns and disease management strategies, which are necessary management tools for payers who want to control costs, maintain quality and improve outcomes.

Actual Cost		Expected Cost		Efficiency Rate	Efficient Use of Services
$9M	/	$9.8M	=	0.92 or 92%	Y
$10M	/	$9.8M	=	1.02 or 102%	N

Shared savings pool calculation

- By comparing the actual medical and pharmacy cost to the 3M expected cost, AmeriHealth Caritas North Carolina calculates the actual versus expected cost ratio.
- A practice's panel whose actual medical cost is exactly equal to the expected medical and pharmacy costs would have an actual versus expected cost ratio of 1, or 100%, indicating that the panel cost is exactly as expected for the health mix of the attributed population.
- An actual versus expected cost ratio of less than 100% indicates a lower than expected spend and, therefore, a savings.
- A savings percentage is then calculated using the difference between 100% and the practice's actual versus expected cost ratio. This savings percent is capped at 10%. Should the result of this calculation be greater than 10%, 10% will be used.
- The shared savings pool will be equal to the savings percent times the practice's paid claims for primary care services. The pool will be distributed across the components as described below.

Example	Expected Rate		Efficiency Rate		Pool %		Practice's PCP Paid Claims		Shared Savings Pool
Non-CAP	100%	–	92%	=	8%	x	100k	=	$8,000
CAPPED	100%	–	73%	=	10%	x	100k	=	$ 10,000

PerformPlus Total Cost of Care payment

Using the shared savings pool calculations, a performance incentive payment associated with quality performance will be paid on a biannual basis. All payments under this program are in addition to the group or solo practice's base reimbursement. The payment amount will be calculated based on the TIN's quality performance and then compared to the established targets for each identified measure. The percentage of measures met will be applied to the shared savings pool to determine the TCOC payment.

Payment cycle	Enrollment	Claims paid through	Payment date
1	**1/1/24 – 6/30/24**	**September 30, 2024**	**December 2024**
2	**7/1/24 – 12/31/24**	**March 31, 2025**	**June 2025**

Quality performance measures

This component is based on quality performance measures consistent with Healthcare Effectiveness Data and Information Set (HEDIS) specifications. In addition, this component is predicated on the AmeriHealth Caritas North Carolina Preventive Health Guidelines and other established clinical guidelines.

PCP quality performance is measured on services rendered during the reporting period and requires accurate and complete encounter reporting. Please note: For each quality performance (HEDIS) measure, participating TINs must have a minimum of five members in the denominator who meet the HEDIS measurement definition requirements.

Helpful hints to improve your HEDIS performance:

- Use your member roster to identify and contact patients who are due for an examination or are newly assigned to your practice.
- Take advantage of this program guide, applicable coding information, and online resources to assist your practice with understanding each HEDIS measure to maximize compliance with HEDIS requirements.
- Use your gaps-in-care member list to reach out to patients in need of services or procedures.
- Schedule the member's next well visit at the end of the current appointment.
- Assign a staff member with HEDIS knowledge or experience to complete ongoing internal reviews and serve as the point person for AmeriHealth Caritas North Carolina's Quality Management staff.
- Institute HEDIS alerts and flags in your electronic health records (EHRs) to notify office personnel of patients in need of HEDIS services.

Quality performance measures	
Child and Adolescent Well-Care Visits (WCV)	**Measure description:** The percentage of members who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year **Eligible members:** 3 – 21 years as of December 31 of the measurement year **Report three age stratifications and total rate:** • 3 – 11 years • 12 – 17 years • 18 – 21 years Total = the sum of all the qualifying age stratifications **Continuous enrollment:** The measurement year **Allowable gap:** No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage (e.g., a member whose coverage lapses for two months [60 days] is not considered continuously enrolled).
Well-Child Visits in the First 30 Months of Life — 0 to 15 months (W30)	**Measure description/rate calculation:** The percentage of members who had well-child visits with a PCP during the last 15 months: • **Well-child visits in the first 15 months:** six or more well visits **Eligible members:** Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days. **Continuous enrollment:** 31 days – 15 months of age. Calculate 31 days of age by adding 31 days to the date of birth. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Well-Child Visits in the First 30 Months of Life — 15 to 30 months (W30)	**Measure description/rate calculation:** The percentage of members who had well-child visits with a PCP during the last 15 months: • **Well-child visits for ages 15 – 30 months:** two or more well visits. **Eligible members:** Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days. **Continuous enrollment:** 15 months plus 1 day – 30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Quality performance measures	
Cervical Cancer Screening (CCS)	**Measure description:** The percentage of members 21 – 64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria: • Members 21 – 64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. • Members 30 – 64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Members 30 – 64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years. **Eligible members:** Members 21 – 64 years as of December 31 of the measurement year. **Continuous enrollment:** The measurement year **Allowable gap:** No more than one gap in enrollment of up to 45 days during the measurement year.
Plan All-Cause Readmission	**Measurement description:** For members 18 – 64 years of age, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. **Eligible members:** For members 18 – 64 years of age, as of the Index Discharge Date. **Continuous enrollment:** 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Childhood Immunization Status (Combo 10)	**Measure description:** 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 measure calculates a rate for each vaccine and nine separate combination rates. **Eligible members:** Children who turn 2 years of age during the measurement year. **Continuous enrollment:** 12 months prior to the child's second birthday **Allowable gap**: No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday.
Immunization for Adolescents (Combo 2)	**Measure description:** The percentage of adolescents age 13 years who had one dose of meningococcal conjugate vaccine; one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine; and completed the human papillomavirus (HPV) vaccine series by their 13th birthdays. **Eligible members:** Members age 13 during the measurement year who have not had a previous anaphylactic reaction to the vaccine. **Continuous enrollment:** 12 months prior to the 13th birthday. **Allowable gap:** No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday.

Quality performance measures	
Glycemic Status Assessment for Patients With Diabetes — Glycemic Status >9% (GSD)	**Measurement description:** The percentage of members 18 – 75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: • Glycemic Status >9.0%. **Eligible members:** 18 – 75 years as of December 31 of the measurement year **Continuous enrollment:** The measurement year **Allowable gap:** No more than one gap in enrollment of up to 45 days during the measurement year
Controlling High Blood Pressure (CBP)	**Measurement definition:** Members 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year **Eligible members:** 18 – 85 years as of December 31 of the measurement year **Continuous enrollment:** The measurement year **Allowable gap:** No more than one gap in continuous enrollment of up to 45 days during the measurement year
Chlamydia Screening in Women (CHL)	**Measurement description:** 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 measurement year **Eligible members:** Women 16 – 24 years as of December 31 of the measurement year Report two age stratifications and a total rate: • 16 – 20 years • 21 – 24 years • Total **Continuous enrollment:** The measurement year **Allowable gap:** No more than one gap in enrollment of up to 45 days during the measurement year

Note

The submission of accurate and complete claims data is critical to ensuring your practice receives the correct calculation based on the services performed for AmeriHealth Caritas North Carolina members.

If you do not submit claims reflecting the measures shown on pages 7 through 9 (where applicable), your performance ranking will be adversely affected, thereby reducing your incentive payment.

Quality performance measures incentive calculation

The shared savings pool (described in a preceding section) is allocated based on performance for quality measures as described above.

Quality measure rates are calculated for each TIN participating in the TCOC Program. This rate is calculated by dividing the number of members who received the service (numerator) by the number of members eligible to receive the service (denominator).

Results will be calculated for each of the aforementioned quality performance measures for each TIN and then compared to the established targets in each payment cycle. (See Table A for 2024 North Carolina Department of Health and Human Services [NCDHHS] quality benchmark targets.)

Table A

Measure	2024 DHHS target*
Child and Adolescent Well-Care Visits (WCV)	53.31%
Well-Child Visits in the First 30 Months of Life — 0 to 15 months (W30)	66.17%
Well-Child Visits in the First 30 Months of Life — 15 to 30 months (W30)	72.50%
**Plan All-Cause Readmission — observed to expected ratio	.77
Childhood Immunization Status (CIS)	35.85%
Immunization for Adolescents (IMA)	31.44%
Cervical Cancer Screening (CCS)	55.04%
Chlamydia Screening in Women (CHL)	61.26%
Glycemic Status Assessment for Patients With Diabetes — Glycemic Status >9% (GSD)	72.74%
Controlling High Blood Pressure (CBP)	25.74%

*Subject to change based on release of NCDHHS standard plan measure targets. Calculations for the 2024 program will be based on 2024 NCDHHS quality benchmark targets.

**Score must be lower than the target for these measures.

The TCOC efficiency component and quality performance component are evaluated independently. Although maximum earnings are tied to performance for both components, an incentive can still be earned on quality measures, even if the TCOC efficiency component is not met.

Scenario	Count of measures met	Total measures meeting minimum denominator	Payout percentage
1	5	10	50%
2	2	6	33%
3	4	4	100%

AmeriHealth Caritas North Carolina

PerformPlus™ Total Cost of Care Program

Measurement Period: 1/1/2024 - 9/30/2024

Payment Period: December 2024

Tax Name:	ABC MEDICAL GROUP	**Member Months:**	3,150
Tax ID:	123456789	**Total Earned:**	$7,308.00

The performance component incentive payment is based on a Total Cost of Care risk adjusted share savings pool. This shared savings pool is available to groups whose attributed member population members demonstrate an efficient use of services relative to the health of the overall population.
Efficient use of services is defined as having actual medical and pharmacy cost less than the expected medical and pharmacy cost in the measurement year.

Total Cost of Care Summary

Actual Med/Pharm Costs:	$1,144,894.27	**Claims Paid in Measurement Period:**	$125,177.24
Expected Med/Pharm Costs:	$1,181,928.31	**Shared Savings Pool:**	$3,922.30
Actual vs Expected Costs:	96.87%	**Percent of Measures Met:**	85.71%
Payable Savings Percent:	3.13%	**Shared Savings Earned:**	$3,370.50

Quality Performance Summary

Quality Metrics	Numerator	Denominator	Rate	Target
Cervical Cancer Screening	1	9	11.11%	55.04%
Chlamydia Screening (HEDIS) - Total	23	29	79.31%	61.26%
Childhood Immunizations (Combo 10)	4	11	36.36%	35.85%
Immunization for Adolescents (Combo 2)	5	12	41.67%	31.44%
Plan All-Cause Readmissions	N/A	N/A	N/A	.7700
Child and Adolescent Well-Care Visits (Total)	255	412	61.89%	53.31%
Well-Child Visits in the First 30 Months of Life 0-15 Months	5	5	100.00%	66.17%
Well-Child Visits in the First 30 Months of Life 15-30 Months	5	6	83.33%	72.50%
Glycemic Status Asst for Patients w/Diabetes >9%	N/A	N/A	N/A	72.74%
Controlling High Blood Pressue	N/A	N/A	N/A	25.74%

Measures Met: 6 **Measures Eligible:** 7 **Percent:** 85.71% **Quality Earned PMPM:** $1.25 **Quality Earned:** $3,937.50

Earnings/Potential Earnings Summary

Shared Savings Earned:	$3,370.50	**Shared Savings Potential Earnings:**	$3,922.30
Quality Earned:	$3,937.50	**Quality Potential Earnings:**	$4,599.00
Total Earned:	$7,308.00	**Total Potential Earnings:**	$8,521.30

Group Detail

Group Name	Group ID	Member Months	Group Payment
ABC GROUP 2	98765410	2,150	$4,988.00
ABC GROUP 1	98765412	1,000	$2,320.00

Available resources

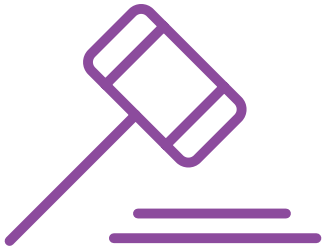
- Your Provider Network Management Account Executive can familiarize you with the TCOC Program and provide additional training to you and your staff.
- NaviNet — Participating primary care providers can access this secure provider portal and resolve HEDIS Care Gaps for ACNC members. Learn more about resolving care gaps in the NaviNet Provider Portal.

Provider appeal of incentive calculations or ranking determination

- If a provider wishes to appeal any or all incentive components, the appeal must be in writing.
- The written appeal must be addressed to the AmeriHealth Caritas North Carolina Chief Medical Officer and include a detailed description of the appeal.
- The appeal must be submitted within 60 days of receiving the information/results from AmeriHealth Caritas North Carolina.
- The appeal and all supporting documentation will be reviewed by the AmeriHealth Caritas North Carolina TCOC Review Committee.
- If the TCOC Review Committee rules in favor of the provider and an adjustment or correction is required, it will be included in the next scheduled payment cycle following committee approval.

Important notes and conditions

1. The total annual sum of incentive payments awarded to a specific group or solo practice for the TCOC program will not exceed 25% of the total AmeriHealth Caritas North Carolina annual reimbursement paid for medical and administrative services. Only capitation and fee-for-service payments are considered part of total reimbursement for medical and administrative services.
2. The quality performance measures are subject to change at any time upon written notification. AmeriHealth Caritas North Carolina will continuously evaluate and enhance its quality management and quality assessment systems. As a result, new quality variables may be added periodically, and criteria for existing quality variables may be modified.
3. For computational and administrative ease, no retroactive adjustments except for those associated with TCOC appeals, will be made to incentive payments. All per member, per month (PMPM) payments will be paid according to the known membership at the beginning of each month.



If a provider wishes to appeal their percentile ranking on any or all incentive components, this appeal must be in writing.

If you have any questions about the program or your program results, please contact your Account Executive.

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