PerformPlus® Total Cost of Care for Primary Care Physicians

Improving quality care and health outcomes

2025

AmeriHealth Caritas™
Ohio

AmeriHealth Caritas Ohio

5525 Parkcenter Circle, Suite 100
Dublin, OH 43017

Dear Primary Care Provider:

AmeriHealth Caritas Ohio's PerformPlus Total Cost of Care (TCOC) for Primary Care Physicians program provides incentives for high-quality and cost-effective care, member service and convenience, and health data submission.

AmeriHealth Caritas Ohio is excited about our enhanced incentive program and will work with your primary care practice so you can maximize your revenue while providing quality and cost-effective care to our members.

Thank you for your continued participation in our network and your commitment to our members. If you have any questions, please contact your assigned Provider Account Executive or email **ohioproviderservices@amerihealthcaritasoh.com** for assistance.

Sincerely,

Robert Metzler
Manager, Provider Network Management

www.amerihealthcaritasoh.com

Introduction

PerformPlus Total Cost of Care (TCOC) for Primary Care Physicians is an upside only reimbursement system developed by AmeriHealth Caritas Ohio (the Plan) for participating primary care practitioners (PCPs).

PerformPlus 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 is the most important determinant of the additional compensation. As additional meaningful measures are developed and improved, the quality indicators contained in PerformPlus TCOC will be refined. The Plan reserves the right to make changes to this program at any time and shall provide written notification of any changes.

Program overview

PerformPlus TCOC is intended to be a program that provides financial incentives over and above a PCP practice's base compensation. Incentive payments are not based on individual performance, but rather the performance of your practice, unless you are a solo practitioner.

PerformPlus TCOC components can only be measured effectively for offices whose panels averaged 20 members at the Taxpayer Identification Number (TIN) level for a defined average enrollment period. For tax entities with fewer than 50 members, there is insufficient data to generate appropriate and consistent measures of performance. These providers are not eligible for participation in PerformPlus TCOC.

A Total Cost of Care incentive will accompany the settlement for groups who performed at or above the established targets for the quality measures of the program and whose actual medical costs were lower than expected medical costs.

1. Quality Performance

This component is based on quality performance measures consistent with HEDIS technical specifications and predicated on the AmeriHealth Caritas Ohio Preventive Health Guidelines and other established clinical guidelines.

These measures are based on services rendered during the reporting period and require accurate and complete encounter reporting. Please note that each measure requires participating PCP providers to have a minimum of five members who meet the HEDIS eligibility requirements detailed next to the HEDIS measure.

The Quality Performance measures are:

Measure	Measure description/ rate calculation	Eligible members	Continuous enrollment	Allowable gap
Antidepressant Medication Management — Effective Acute Phase Treatment	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks).	18 years and older as of the index prescription start date (IPSD).	105 days prior to the IPSD through 231 days after the IPSD.	One gap in enrollment of up to 45 days.
Child & Adolescent Well-Care Visits (ages 12 – 17)	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 measurement year; 12 – 17 years of age stratification.	12 – 17 years of age as of December 31 of the measurement year.	The measurement year.	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Child & Adolescent Well-Care Visits (ages 18 – 21)	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 measurement year; 18 – 21 years of age stratification.	18 – 21 years of age as of December 31 of the measurement year.	The measurement year.	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Child & Adolescent Well-Care Visits (ages 3 – 11)	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 measurement year; 3 – 11 years of age stratification.	3 – 11 years of age as of December 31 of the measurement year.	The measurement year.	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Controlling High Blood Pressure	The percentage of members 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.	18 – 85 years as of December 31 of the measurement year.	The measurement year.	No more than one gap in continuous enrollment of up to 45 days during the measurement year.

Quality Performance measures (*continued from page 5*)

Measure	Measure description/ rate calculation	Eligible members	Continuous enrollment	Allowable gap
Follow-Up After Emergency Department Visit for Mental Illness (ages 6 – 17)	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the ED visit (8 total days).	6 – 17 years as of the date of the ED visit.	Date of the ED visit through 30 days after the ED visit	None.
Glycemic Status Assessment for Patients With Diabetes (GSD) (> 9.0%)	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 glycemic status > 9.0% during the measurement year.	18 – 75 years as of December 31 of the measurement year.	The measurement year.	No more than one gap in enrollment of up to 45 days during the measurement year.
Prenatal/ Postpartum Care — Postpartum Care	The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	No age specified.	43 days prior to delivery through 60 days after delivery.	None.
Prenatal/ Postpartum Care — Timeliness of Prenatal Care	The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization.	No age specified.	43 days prior to delivery through 60 days after delivery.	None.
Well-Child Visits in the First 15 Months of Life (6 or more visits)	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. Children who turned 15 months old during the measurement year: Six or more well-child visits.	Children who turn 15 months old during the measurement year.	31 days – 15 months of age.	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.

Note: The submission of accurate and complete encounters is critical to ensure your practice receives the correct calculation, based on the services performed for AmeriHealth Caritas Ohio members.

Note: If you do not submit encounters reflecting the measures shown on pages 5 and 6 (where applicable), your ranking will be adversely affected, thereby reducing your incentive payment.

Target Rates — Cycles 1 – 4

Quality measures	Q1	Q2	Q3	Q4
Antidepressant Medication Management — Effective Acute Phase Treatment	56.65%	57.39%	57.35%	57.51%
Child & Adolescent Well-Care Visits (ages 12 – 17)	20.50%	36.99%	49.07%	53.10%
Child & Adolescent Well-Care Visits (ages 18 – 21)	11.74%	18.97%	24.13%	24.53%
Child & Adolescent Well-Care Visits (ages 3 – 11)	26.03%	42.39%	54.62%	56.03%
Controlling High Blood Pressure	42.45%	53.03%	60.49%	61.31%
Follow-Up After Emergency Department Visit for Mental Illness (ages 6 – 17)	54.05%	68.92%	76.88%	74.32%
Glycemic Status Assessment for Patients With Diabetes (GSD) (> 9.0%)	55.41%	48.79%	45.09%	44.04%
Prenatal/Postpartum Care — Postpartum Care	67.58%	70.33%	77.52%	78.10%
Prenatal/Postpartum Care — Timeliness of Prenatal Care	90.18%	90.37%	90.49%	84.23%
Well-Child Visits in the First 15 Months of Life (6 or more visits)	46.55%	55.18%	57.39%	63.44%

2. Total Cost of Care Performance

The Total Cost of Care component for the program represents an actual versus expected medical cost analysis that determines an efficient use of services based on the population being served. This efficient use of services calculation is what ultimately establishes a shared savings pool that is then made available to providers based on their quality performance across the state-focused measures in the program.

Total Cost of Care — efficient use of services calculation

Efficient use of services is defined as having an actual medical and pharmacy spend that is less than the expected medical and pharmacy spend (as determined using the 3M™ Clinical Risk Groups [CRG]) in the measurement year. By comparing the actual cost to the expected cost, AmeriHealth Caritas Ohio calculates an actual versus expected cost ratio.

The actual versus expected cost ratio is the ratio of the actual medical and pharmacy cost to the expected cost. A practice's panel whose actual medical cost is exactly equal to the expected medical cost 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. The savings percentage is then calculated using the difference between 100% and the practice's actual versus expected cost ratio. This savings percentage is capped at 10%. If the result of this calculation is greater than 10%, 10% will be used. The shared savings pool will be equal to the savings percentage multiplied by the practice's reimbursement for services rendered during the claims period and then multiplied by a factor to increase the earning potential for high performers.

Total Cost of Care — provider performance earnings example

For example, Provider X had an actual medical cost of $950,000 versus an expected medical cost of $1,000,000. This results in a 95% efficient use of services score, with a margin of 5%. The provider was reimbursed $100,000 in claims spend during the measurement period, which would result in establishing a shared savings pool of $5,000 [provider spend × margin × factor] available to the provider to earn through this program.

The amount of dollars earned from this shared savings pool is then determined by how well the providers performed across the ten quality measures in the program when compared to targets achieved.

The total targets achieved across all eligible measures divided by the potential targets achieved per measure determines the percentage of the shared savings pool to be incentivized to the provider. For example, of the ten HEDIS measures, Provider X had an adequate sample size for eight of them, and achieved the established target for four of the possible eight measures. Earned targets of four divided by potential targets of eight equals 50%, and that percentage times the previously established $5,000 shared savings pool via the Total Cost of Care component of the program would result in a $2,500 incentive earned. The total incentive payment earned is also based your current panel status. If a provider is "open," they are eligible for 100% of the earned incentive. If a panel is "current patients only," they are eligible for 50% of the earned incentive. If a panel is "closed," the provider is not eligible for an incentive.

AmeriHealth Caritas Ohio

PerformPlus™ Total Cost of Care for PCPs

Cycle 4 Measurement Period: January 1st, 2025 - December 31st, 2025

Tax ID: 111111111
Tax Name: ABC Provider INC

Panel Average Enrollment: 139
Total Member Months: 1,668

Total Cost of Care Summary

Actual Cost	Expected Cost	Actual vs Expected Cost Ratio	Claims Paid Amount In Measurement Period	Max Potential Program Pool
$950,000.00	*$1,000,000.00*	*95.00%*	*$100,000.00*	*$5,000.00*

Quality Performance Summary

HEDIS Measure Detail	Rate	Target	Target Met
Antidepressant Medication Management - Acute	*59.03%*	*57.51%*	*YES*
Child Adolescent Well-Care Visits (3 -11)	*53.26%*	*56.03%*	*NO*
Child Adolescent Well-Care Visits (12- 17)	*52.85%*	*50.55%*	*YES*
Child Adolescent Well-Care Visits (18 -21)	*23.27%*	*24.53%*	*NO*
Controlling High Blood Pressure	*N/A*	*61.31%*	*N/A*
Glycemic Status Assessment for Patients With Diabetes (>9.0%)	*41.44%*	*44.04%*	*YES*
Follow-Up After Hospitalizations for Mental Illness - 7 Days [ages 6-17]	*37.29%*	*74.32%*	*NO*
Prenatal /Postpartum Care – Timeliness of Prenatal Care	*85.74%*	*84.23%*	*YES*
Prenatal /Postpartum Care – Postpartum Care	*64.35%*	*78.10%*	*NO*
Well-Child Visits in the First 15 Months of Life (6 or more visits)	*N/A*	*58.66%*	*N/A*

** N/A = DOES NOT MEET DENOM THRESHOLD*

Incentive Summary

Total Measures Met/Total Potential Measres:	Total Percentage Points:	Program Payout:
4 / 8	*50.00%*	*$2,500.00*

Group Detail

Group Name	Group ID	Group MM	Group Payment
ABC Provider 1	1023149	1,668	**$2,500.00**

2024 Incentive Timeline

Payment cycle	Measurement Period	Claims Period	Total Cost of Care Period	Pay Date
1	1/1/2025 – 6/30/2025	1/1/25 – 3/31/25	4/1/24 – 3/31/25	September 2025
2	1/1/2025 – 9/30/2025	4/1/25 – 6/30/25	7/1/24 – 6/30/25	December 2025
3	1/1/2025 – 12/31/2025	7/1/25 – 9/30/25	10/1/25 – 9/30/25	March 2026
4	1/1/2025 – 12/31/2025 + runout	10/1/25 – 12/31/25	1/1/25 – 12/31/25	June 2026

Provider appeal of ranking determination

- If a provider wishes to appeal their percentile ranking on any or all incentive components, this appeal must be made in writing.
- The written appeal must be addressed to the Market Chief Medical Officer of the Plan and specify the basis for the appeal.
- The appeal must be submitted within 60 days of receiving the overall ranking from the Plan.
- The appeal will be forwarded to the Plan's Review Committee for review and determination.
- If the Plan's Review Committee determines that a ranking correction is warranted, an adjustment will appear on the next payment cycle following committee approval.

Important notes and conditions

1. The sum of the incentive payments for the program will not exceed 33% of the total compensation for medical and administrative services. Only capitation and fee-for-service payments are considered part of the total compensation for medical and administrative services.
2. The Quality Performance measures are subject to change at any time upon written notification. The Plan will continuously improve and enhance its quality management and quality assessment systems. As a result, new quality variables will periodically be added, and criteria for existing quality variables will be modified.
3. For computational and administrative ease, no retroactive adjustments will be made to incentive payments.

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