PerformPlus® Total Cost of Care – Primary Care Providers

Improving quality care and health outcomes

2025

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AmeriHealth Caritas®
North Carolina

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Dear Primary Care Provider:

Thank you for participating in the AmeriHealth Caritas North Carolina's (ACNC's) PerformPlus Total Cost of Care (TCOC) program.

The 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 2025 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,

Steven Spalding, MD
Market Chief Medical Officer

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 taxpayer 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 1, 2 and 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 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	1/1/25 - 6/30/25	September 30, 2025	December 2025
2	7/1/25 - 12/31/25	March 31, 2026	June 2026

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 30 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.
- Ensure your practice is providing electronic data to ACNC through our data exchange vendors.

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).
Screening for Depression and Follow-Up (CDF)	**Measure description:** The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care with an outpatient encounter. • **Depression screening:** The percentage of members who were screened for clinical depression using a standardized instrument. • **Follow-up on positive screen:** A follow up plan must be documented on the date of the qualifying encounter for a positive depression screen. **Eligible members:** Members 12 years of age and older at the start of the measurement period who have never been diagnosed with bipolar disorder.
Colorectal Cancer Screening (COL-E)	**Measure description:** The percentage of members 45 - 75 years of age who had appropriate screening for colorectal cancer **Eligible members:** Members 45 - 75 years within 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

Quality performance measures	
Childhood Immunization Status (CIS-E) **(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.
Glycemic Status Assessment for Patients With Diabetes – Glycemic Status <8% (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 <8.0%. **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

** This measure will also be considered a health equity measure for our African American population.

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 Payment Cycle 1 Metric Targets (1/1/2025 to 6/30/2025) for 2025 NCQA tiered quality benchmark targets.] If the TIN achieves the tier 1 target for all measures, they will be eligible to receive up to $1.00 PMPM. Based on tier level performance, the group will be eligible to earn an additional amount PMPM up to $1.75 PMPM for the highest level of performance. The amount they receive for each measure is dependent on performance for that measure. For calculation of incentives, all measures will be weighted equally. Payment Cycle 1 Metric Targets (1/1/2025 to 6/30/2025) and Payment Cycle 1 Metric Targets (1/1/2025 to 12/31/2025) include detail for the biannual and annual targets, as well as all tiers. A sample calculation can be found beneath these two tables. The sample calculation is for illustrative purposes only and does not reflect actual results for the performance period.

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.

Payment Cycle 1 Metric Targets (1/1/2025 through 6/30/2025)				
Quality metric	**Tier 1 (10th percentile); 25% of potential PMPM**	**Tier 2 (25th percentile); 50% of potential PMPM**	**Tier 3 (50th percentile); 75% of potential PMPM**	**Tier 4 (75th percentile); 100% of potential PMPM**
Childhood Immunizations Status (Combo 10) (CIS-E)	9.13%	11.44%	13.75%	17.40%
Childhood Immunizations Status (Combo 10) (CIS-E) – Health Equity	8.85%	9.10%	9.36%	9.62%
Immunization for Adolescents (Combo 2)	12.71%	14.86%	17.15%	20.81%
Child and Adolescent Well-Care Visits (WCV)	20.92%	23.29%	25.91%	29.04%

Payment Cycle 1 Metric Targets (1/1/2025 through 6/30/2025)				
Quality metric	Tier 1 (10th percentile); 25% of potential PMPM	Tier 2 (25th percentile); 50% of potential PMPM	Tier 3 (50th percentile); 75% of potential PMPM	Tier 4 (75th percentile); 100% of potential PMPM
Controlling High Blood Pressure (CBP)	27.31%	29.87%	32.24%	34.69%
Screening for Depression and Follow-Up (CDF)	1.27%	3.77%	6.27%	8.77%
Glycemic Status Assessment for Patients With Diabetes – < 8%(GSD)	22.13%	25.79%	28.71%	30.42%
Colorectal Cancer Screening (COL-E)	13.64%	15.79%	19.04%	21.86%

Payment Cycle 2 Metric Targets (1/1/2025 through 12/31/2025)				
Quality metric	Tier 1 (10th percentile); 25% of potential PMPM	Tier 2 (25th percentile); 50% of potential PMPM	Tier 3 (50th percentile); 75% of potential PMPM	Tier 4 (75th percentile); 100% of potential PMPM
Childhood Immunizations Status (Combo 10) (CIS-E)	18.25%	22.87%	27.49%	34.79%
Childhood Immunizations Status (Combo 10) (CIS-E) – Health Equity	17.69%	18.20%	18.72%	19.23%
Immunization for Adolescents (Combo 2)	25.41%	29.72%	34.30%	41.61%
Child and Adolescent Well-Care Visits (WCV)	41.83%	46.57%	51.81%	58.07%
Controlling High Blood Pressure (CBP)	54.61%	59.73%	64.48%	69.37%
Screening for Depression and Follow-Up (CDF)	2.54%	7.54%	12.54%	17.54%
Glycemic Status Assessment for Patients With Diabetes – < 8%(GSD)	44.25%	51.58%	57.42%	60.83%
Colorectal Cancer Screening (COL-E)	27.27%	31.58%	38.07%	43.71%

Illustrative example of incentive calculation	Tier 1	Tier 2	Tier 3	Tier 4
Total PMPM Earnings	$1.00	$1.25	$1.50	$1.75
Total Measures	8	8	8	8
Per Measure PMPM	$0.13	$0.16	$0.19	$0.22
Members	2,500	2,500	2,500	2,500
Member Months	30,000	30,000	30,000	30,000
Measures Met	5	3	1	1
Measure Met Payout	$18,750.00	$14,062.50	$5,625.00	$6,562.50
Total Payout				$45,000.00

Tier legend
Tier 1 (10th percentile); $1.00 PMPM
Tier 2 (25th percentile); $1.25 PMPM
Tier 3 (50th percentile); $1.50 PMPM
Tier 4 (75th percentile); $1.75 PMPM

Payment schedule

Payment cycle	Reporting period	Payment date
Cycle 1	1/1/2025 - 6/30/2025	December 2025
Cycle 2	1/1/2025 - 12/31/2025	June 2026

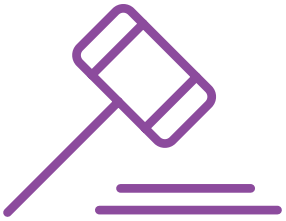
Available resources

- 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.
- The 3M™ Medical Home Dashboard supports the implementation of accountable care programs, medical homes and other programs by providing users with quick, easy access to critical key performance indicators. The dashboard is refreshed by 3M once a month to make the most up-to-date data available to users.

- After submitting the required form and receiving approval to have access, you can access the 3M Health Information System (HIS) online portal using your email address as your user ID.

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 Provider Advisory Council.
- If the Provider Advisory Council 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.



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

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.
4. Providers with practice-specific value-based payment models are excluded from this program. Check with with your ACNC Account Executive to determine your eligibility.

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

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North Carolina

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