PerformPlus™ Total Cost of Care Program

Improving quality care and health outcomes

May 2024

www.amerihealthcaritasnh.com

AmeriHealth Caritas™
New Hampshire

Dear Primary Care Provider:

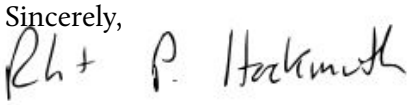
As we enter the fifth year of the program, AmeriHealth Caritas New Hampshire's is pleased to present the **PerformPlus™ Total Cost of Care** (TCOC) Program, formerly the Quality Enhancement Program (QEP), which continues to provide incentives for high-quality and cost-effective care, excellent member service during office visits, and health data submission. A significant number of providers achieved their incentives during the first four years of the program.

We are continuing the HEDIS Care Gap Closure payment that incentivizes providers for billing CPT II codes to close care gaps in important HEDIS measures (outlined later in this manual).

AmeriHealth Caritas New Hampshire is excited about our incentive program. We will actively work with your primary care practice to help you achieve offered incentives while providing high-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 Provider Network Management Account Executive.

Sincerely,



Robert P. Hockmuth, M.D.
Chief Medical Officer

Introduction

PerformPlus™ Total Cost of Care (TCOC) Program is an incentive system developed by AmeriHealth Caritas New Hampshire for participating primary care providers (PCPs).

The program 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.

AmeriHealth Caritas New Hampshire reserves the right to make changes to this program at any time and will provide written notification of any changes.

Program overview

The program provides financial incentives beyond a PCP practice's base compensation. Incentive payments are not based on individual provider performance, but on the performance of your practice, unless you are a solo provider.

PCP offices whose panels average 50 or more members are eligible for this program. The average of 50 is based on a defined average enrollment period (semi-annually) for the particular measurement year. For offices with panel sizes of fewer than 50 members for the measurement period, there is insufficient data to generate appropriate and consistent measures of performance. These practices are not eligible for participation in the program.

Program specifications

The program is designed to reward higher performance by practices that meet financial and quality benchmarks by reducing unnecessary costs and delivering quality health care for our 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.

1. 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 clinical risk group (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.

Shared savings pool calculation

By comparing the actual medical and pharmacy cost to the 3M expected cost, AmeriHealth Caritas New Hampshire calculates the actual versus expected cost ratio.

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**

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.

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 25%. Should the result of this calculation be greater than 25%, 25% will be used.

The shared savings pool will be equal to the savings percent times the practice's paid claims for primary care services.

Example:

	Expected Rate		Efficiency Rate		Pool %		Practice's PCP Paid Claims		Shared Savings Pool
Non-capped	100%	–	92%	=	8%	×	$100,000	=	$8,000
Capped	100%	–	73%	=	25%	×	$100,000	=	$25,000

The pool will be distributed across the components as described below.

Performance incentive payment (PIP)

Using the shared savings pool calculated earlier, a performance incentive payment (PIP) associated with quality performance will be paid on a biannual basis (PIP payment schedule). All PIP payments are in addition to the group or solo practice's base reimbursement. The payment amount will be calculated based on the PCP group or solo practice performance compared to their peers on each identified measure.

- **Quality performance(semi-annual).**
- **Potentially preventable admissions (PPA) (annual).**
- **Potentially preventable emergency room visits (PPV) (annual).**
- **Pulse Member Satisfaction Survey (annual).**

As additional meaningful measures are developed and improved, the program's quality indicators will be refined. AmeriHealth Caritas New Hampshire reserves the right to make changes to this program at any time and will provide written notification of any changes.

CPT II Care Gap closure incentive

This component of the program is based on timely submissions of CPT II codes for the HEDIS measures listed below. There will be a $20 payment for each CPT II code submitted that closes the gap for the specified HEDIS measure.

Quality performance measures	
Glycemic Status Assessment for Patients With Diabetes (GSD)	**Measure summary:** The percentage of adult members with diabetes (Type 1 or Type 2) who had at least one annual HbA1c test with a level below 8. Evidence is a medical record or a claim. This measure has an additional claim incentive when evidence to support the measure adherence, referred to as closing the gap in care, is submitted to AmeriHealth Caritas New Hampshire via a claim. **For your patients who have a diagnosis of diabetes, closing the Gap in Care for HbA1c Control with a level below 8.** Please include the HbA1c result CPT II code below that best matches the HbA1c reading and include the collection date as the date of service. **CPT II code —most recent HbA1c reading — incentive amount** **3044F** — HbA1c level less than 7 — **$20** **3051F** — HbA1c level greater than or equal to 7 and less than 8 — **$20**
Controlling High Blood Pressure (CBP)	**Measure summary:** The percentage of adult members with hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during a calendar year. Evidence is a medical record or a claim. This measure has an additional claim incentive when evidence to support the measure adherence, referred to as closing the gap in care, is submitted to AmeriHealth Caritas New Hampshire via a claim. **For your patients who have a diagnosis of hypertension, closing the gap in care for blood pressure with a blood pressure reading below 140/90.** Please include on the claim the blood pressure reading CPT II code below that best matches the blood pressure systolic reading below 140 **and** the diastolic reading below 90. You **must** include **both** the systolic **and** diastolic CPT II codes below that best match the BP reading. This indicates BP control on the same claim on the date of service the blood pressure reading was taken. **CPT II code — most recent systolic/diastolic blood pressure reading — incentive amount** **3074F —** Systolic below 130 mmHg — **$10** **3078F —** Diastolic below 80 mmHg — **$10** **3075F** — Systolic between 130 and 139 mmHg — **$10** **3079F —** Diastolic between 80 and 89 mmHg — **$10**

Quality performance

This component of the program is based on quality performance measures consistent with Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications and predicated on the AmeriHealth Caritas New Hampshire Preventive Health Guidelines and other established clinical guidelines.

These measures are assessed based on services rendered during the reporting period and require accurate and complete encounter reporting. Please note that each measure requires participating PCP groups to have a minimum of five members who meet HEDIS eligibility requirements detailed next to the HEDIS measure to be considered as part of the component for the PIP.

Quality performance measures	
HEDIS Glycemic Status Assessment for Patients With Diabetes (GSD)	**Measure summary:** See CPT II Care Gap closure incentive above.
HEDIS Controlling High Blood Pressure (CBP)	**Measure summary:** See CPT II Care Gap closure incentive above.
HEDIS Child and Adolescent Well-Care Visits (WCV)	**Measure summary:** 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 a calendar year. Evidence is a claim or encounter data submitted to AmeriHealth Caritas New Hampshire.
HEDIS Lead Screening in Children (LSC)	**Measure summary:** The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. Evidence is a claim or encounter data record submitted to AmeriHealth Caritas New Hampshire.
HEDIS Breast Cancer Screening (BCS-E)	**Measure summary:** The percentage of members ages 50 – 74 who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.
HEDIS Human Papillomavirus Vaccine (HPV) Series	**Measure summary:** The percentage of adolescents 13 years of age who have completed the human papillomavirus (HPV) vaccine series by between the age of 9 and before their 13th birthday.

Practice score calculation

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

A rate will be calculated for each of the metrics above for each practice participating in the program. This rate is calculated by dividing the number of members who received the above-described services (numerator) by the number of members eligible to receive the services (denominator). This rate will then be compared to the established targets in each payment cycle. Providers who meet the established targets and have demonstrated an efficient use of services (shared savings pool) will qualify for a payment for that measure. There is no adjustment for the age or sex of the member.

Quality Measure	Target for Payment Cycle 1	Target for Payment Cycle 2
HEDIS Glycemic Status Assessment for Patients With Diabetes (GSD)	50.1%	52.8%
HEDIS Controlling High Blood Pressure (CBP)	59.9%	63.5%
HEDIS Child and Adolescent Well-Care Visits (WCV)	53.5%	57.5%
HEDIS Lead Screening in Children (LSC)	70.1%	72.7%
Human Papillomavirus (HPV) vaccine series	36.5%	40.5%
HEDIS Breast Cancer Screening	57.5%	57.5%

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

Payment cycle	Enrollment	Claims paid through	Payment date
1	January – June	September 30, 2024	December 2024
2	July – December	December 31, 2024	June 2025

Potentially preventable events measures

The following population-focused preventable (PPE) components and industry-standard definitions will be used to measure performance:

Potentially preventable admissions (PPAs) — A hospitalization that could have been prevented with consistent, coordinated care and patient adherence to treatment and self-care protocols. PPAs are ambulatory-sensitive conditions (e.g., asthma) for which adequate patient monitoring and follow-up (e.g., medication management) can often avoid the need for admission. The occurrence of high rates of PPAs represents a failure of the ambulatory care provided to the patient.

Potentially preventable emergency room visits (PPVs) — An emergency room (ER) visit that may result from a lack of adequate access to care or ambulatory care coordination. PPVs are ambulatory-sensitive conditions (e.g., asthma), for which adequate patient monitoring and follow up (e.g., medication management) should be able to reduce or eliminate the need for ER services. In general, the occurrence of high rates of PPVs represents a failure of the ambulatory care provided to the patient.

Potentially preventable events (PPEs) incentive calculation

The PPE component individually evaluates the PPAs and PPVs of the panel members in the Total Cost of Care (TCOC) Program. Results for each PPE will be calculated annually for each group and/or solo provider. Overall practice scores are calculated by dividing the observed number of PPEs by the expected number

of admissions. This score will then be compared to the score for all of the eligible practices to determine the practice percentile ranking for each of the PPEs. Then, the overall score will be the average percentile ranking across all included PPEs. This incentive is paid annually and is based on the practice's overall ranking and the number of members on the practice's panel during the Q4 measurement period. There is no adjustment for age or sex of the member.

Pulse Member Satisfaction Survey

To compensate practices that receive positive member satisfaction survey responses, AmeriHealth Caritas New Hampshire will use a Pulse survey to obtain member feedback regarding their experience during a recent PCP visit.

Pulse member satisfaction incentive

Survey result rates for each practice will be calculated and subject to minimum sample size requirements.

This rate will then be compared to the rate for all qualifying practices to determine the practice's peer-percentile ranking. To qualify for an incentive payment, practices must rank within the top 50th percentile in satisfaction results when compared to their peers.

The member satisfaction survey rate incentive payment is based on each practice's ranking relative to its peer network. This program component is settled annually based on the prior 12-month performance period. The practice's peer percentile rank will be used to determine the per member per month (PMPM) amount earned for the member satisfaction rate component. PMPMs will be established starting at the 50th percentile using 5% increments. This component will be settled annually at the same time as the final quality settlement. PMPM payments are not adjusted for the age or sex of the member.

Important notes and conditions

- Annually, the sum of all AmeriHealth Caritas New Hampshire 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 total compensation for medical and administrative services.
- Quality performance measures are subject to change at any time upon written notification. AmeriHealth Caritas New Hampshire will continuously improve and enhance its quality management and quality assessment systems. As a result, new quality variables will be added periodically, and criteria for existing quality variables will be modified.
- For computational and administrative ease, no retroactive adjustments will be made to incentive payments.
- If you have any questions about the program or your program results, please contact your Account Executive.

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