PerformPlus™ Total Cost of Care – Primary Care Providers

Improving quality care and health outcomes

2025

AmeriHealth Caritas® Delaware

www.amerihealthcaritasde.com

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AmeriHealth Caritas Delaware

Dear Primary Care Provider:

We are pleased to present AmeriHealth Caritas Delaware's PerformPlus™ Total Cost of Care – Primary Care Providers Program,formerly known as the Quality Enhancement Program (QEP). . The Program is specifically designed for PCPs, and pays incentives for delivering high-quality, cost-effective care; providing member services and conveniences; and submitting timely key health data.

AmeriHealth Caritas Delaware is excited about our enhanced incentive program and will work with your practice to assist in maximizing your revenue while providing quality, 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 regarding our program, please contact your Provider Network Account Executive.

Sincerely,

Deborah Allen-Brown, MD
Market Chief Medical Officer

Christopher Bruette
Director Provider Network Management

Program overview

The program is a reimbursement opportunity developed by AmeriHealth Caritas Delaware 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 is the most important determinant of the additional compensation. As new meaningful measures are developed and introduced, the quality indicators contained in the Program will be refined. AmeriHealth Caritas Delaware reserves the right to make changes to this program at any time and will provide written notification of any changes.

Program participation

The program provides financial incentives beyond a PCP practice's base reimbursement. Program performance and associated incentive payments are calculated at the group or solo practice level — not per individual provider.

Eligible providers include:

- PCP groups or solo practices with average panel sizes of 50 or more assigned AmeriHealth Caritas Delaware members during the measurement period*

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

Ineligible providers include:

- PCP practices with average panel sizes of less than 50 AmeriHealth Caritas Delaware members during the measurement period.
- PCP providers with voluntarily closed panels are not eligible to participate in the program.
- PCP providers participating in an AmeriHealth Caritas Delaware value-based purchasing agreement or Accountable Care Organization (ACO) agreement are not eligible to participate 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 3MTM Clinical Risk Groups (CRG) methodology.

The Efficient Use of Services Calculation

The Efficient use of service 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, 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.

Example of Efficiency Rate Calculation

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 Delaware calculates the actual versus expected cost ratio. 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. The pool will be distributed across the components of program, Quality Performance, Potentially Preventable Events and the Member Experience Pulse Survey.

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

Shared Savings Pool Calculation

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%	=	25%	x	100K	=	$25,000

Performance Incentive Payment (PIP)

Using the Shared Savings Pool calculated above, a Performance Incentive Payment (PIP) associated with the Quality performance, Potentially Preventable Events (PPE) and the Member Experience Pulse Survey will be paid on a semi- annual basis (see schedule below). 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.

The Shared Savings Pool is apportioned as follows:

1. Quality performance (100%) First Cycle, (75%) Second Cycle
2. Potentially preventable events (20%) Second Cycle
3. Member Experience Pulse Survey (5%) Second Cycle

Payment schedules are outlined in below.

Payment cycle	Enrollment	Enrollment	Payment date
1	1/1/25 – 6/30/25	June 30, 2025	December 2025
2	7/1/25 – 12/31/25	March 31, 2026	June 2026

1. 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 Delaware Preventive Health Guidelines* and other established clinical guidelines.

PCP quality performance is measured on services rendered during the reporting period and require accurate and complete encounter reporting. **Please note:** For each quality performance (HEDIS) measure, participating PCP groups or solo practitioners must have a minimum of five AmeriHealth Caritas Delaware members 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 Delaware'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.

* Please note that each HEDIS measure requires participating PCP groups to have a minimum of five members who meet the HEDIS eligibility requirements.

Quality performance measures	
Adults' Access to Preventive/Ambulatory Health Services (AAP)	**Measurement definition:** The percentage of members ages 20 and older who had an ambulatory or preventive care visit with any provider type on an outpatient basis during the measurement year.
AMM to Pharmacotherapy for Opioid Use Disorder – Total (POD)	**Measurement definition:** The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.
Asthma Medication Ratio (AMR)	**Measurement definition:** The percentage of members ages 5 to 11 and 12 to 18 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 50% or greater during the measurement year.
Breast Cancer Screening (BCS-E)	**Measurement definition:** This measure captures the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer from October 1 two years prior to the measurement period through the end of the measurement period.. ***Measure exclusion criteria:*** *a woman who had a bilateral mastectomy, unilateral mastectomy with bilateral modifier, two unilateral mastectomies, or unilateral mastectomy with right/left side modifier any time during the member's history through the end of the measurement period.*
Cervical Cancer Screening (CCS-E)	**Measurement definition:** The percentage of women ages 24 to 64 years as of December 31 of the measurement year who were screened for cervical cancer using either of the following criteria: • Women ages 21 to 64 who had cervical cytology performed within the last three years. • Women 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years. • Women 30 to 64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last five years. ***Measure exclusion criteria:*** *a woman who had a hysterectomy with no residual cervix any time during the member's history through the end of the measurement period.*
Child and Adolescent Well- Care Visits (WCV)	**Measurement definition:** The percentage of members three to 21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.

Quality performance measures	
Glycemic Status Assessment for Patients With Diabetes (GSD) <8%	**Measurement definition:** The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (HbA1c or GMI) was less than 8% 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.
Plan All-Cause Readmissions (lower scores are better) Expected/Observed (PCR)	**Measurement definition:** For members 18 years of age and older, 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. The readmission event must occur within 30 days of discharge from an initial qualifying admission. To qualify as an initial admission for this measure, the admission must not indicate the patient was discharged or transferred to a hospital medical facility, federal facility, critical care access hospital, or other rehabilitation facility, or that the patient expired.
Lead Screening in Children (LSC)	**Measurement definition:** 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.

Note

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

If you do not submit claims reflecting the measures shown on pages 6 through 7 (where applicable), your performance ranking will be adversely affected, thereby reducing your incentive payment.

Quality performance measures incentive calculation

A portion of the Shared Savings Pool (described in a preceding section) is allocated to the quality performance incentive. This program pool is calculated semi-annually based on the number of AmeriHealth Delaware members on your panel. There is no adjustment for the age or sex of the member.

Quality measure rates are calculated for each practice participating in the 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). This rate is compared to the rates calculated for all other eligible practices to determine the peer percentile rank. The practice's score for the quality component is the average of the peer percentile ranks of all measures for which the practice's panel met minimum denominator criteria. The average peer percentile rank determines the percent of the shared shavings pool for quality.

See table below for payout percentages.

Level	Practice Score Tier	Payout Percentage
Core	>= 50th	60%
Premium	>= 60th	80%
Elite	>= 75th	100%

Example of Payment Calculation

A	*B*	*C*	*D*	*E*	*F*	*G*		*h*
Component	**Shared Savings Pool**	**Pool Allocation**	**Calculated Pool $8,000**	**Average Percentile Rank**	**Practice Score Level**	**Payout Percentage**		**Earned Incentive**
	$8,000		*(B x C)*					*(D x G)*
Quality		75%	$6,000	50th	Core	60%	=	**$3,600**
Preventable		20%	$1,600	65th	Premium	80%	=	**$1,280**
Pulse		5%	$400	80th	Elite	100%	=	**$400**
					Total Earned Incentive		=	**$5,280**

2. Member Experience Pulse Survey (Annually)

The purpose of the Member Experience Pulse Survey is to assess the member's experience following a provider visit. To make the process easier for members, emojis are incorporated to simplify the responses. For each survey question, a provider is assigned a score. Primary care practices who are eligible to participate in the program and are ranked in the top 50 percent are eligible to earn this annual incentive.

The numerator is calculated for each survey question and a provider is assigned the following score:

Member Experience Survey

• Very dissatisfied:	0 points	• Satisfied:	0.75 points
• Dissatisfied:	0.25 points	• Very Satisfied:	1 point
• Neutral:	0.5 points		

The denominator is developed from each member answer and is counted as one in the denominator.

How the Member Experience Pulse Survey incentive is calculated

A portion of the Shared Savings Pool (described in a preceding section) is allocated to the Pulse Survey incentive. Survey results for each practice are calculated and subject to a minimum sample size requirement. This rate is compared to all qualifying practices to determine the peer percentile ranking. To qualify for an incentive payment, practices must rank within the top 50 percent in satisfaction results when compared to their peers.

3. Potentially Preventable Event (PPE) measures

The population-focused preventable (PFP) components and industry- standard definitions are 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 visit that results from a lack of adequate access to 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.

Member Experience Survey

1. How satisfied are you with how carefully the doctor/care provider listened to you?

2. How satisfied are you with the respect shown by the doctor/care provider for what you had to say?

3. Overall, how woud you rate the doctor/care provider?

4. Comments?

Potentially PreventableEevents (PPEs) incentive calculation — The PPE component evaluates PPAs and PPVs of panel members in the program. Results for each PPE are calculated annually for each group and/or provider. The overall practice score is calculated by dividing the observed number of PPEs by the expected number of admissions. This score is compared to all eligible practices to determine the percentile ranking for each PPE. This annual incentive 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.

Available resources

Your Provider Network Management Account Executive can familiarize you with the 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 AmeriHealth Caritas Delaware members. Learn more about resolving care gaps in NaviNet by visiting **www.amerihealthcaritasde.com > Providers > Resources > NaviNet > Identify and improve HEDIS gaps.**
- **Delaware Health Care Claims Database —** The Delaware Health Care Claims Database (HCCD) is a database powered by the Delaware Health Information Network (DHIN) that collects healthcare claims, enrollment, and provider data from Medicare, Medicaid, and commercial health insurers in the State of Delaware. To learn more about DHIN visit **https://dhin.org/healthcare-claims-database/.**

Provider appeal of incentive calculations or ranking determination

- If a provider wishes to appeal their percentile ranking on any or all incentive components, the appeal must be in writing.
- The written appeal must be addressed to the AmeriHealth Caritas Delaware 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 Delaware.
- The appeal and all supporting documentation will be reviewed by the AmeriHealth Caritas Delaware Review Committee.
- If the program 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 program will not exceed 33% of the total AmeriHealth Caritas Delaware 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 Delaware 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 maybe modified.
3. For computational and administrative ease, no retroactive adjustments with the exception of those associated with program 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.

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