



Integrated Healthcare Association Align. Measure. Perform. (AMP) Programs

Measurement Year 2021 Program Guide (Final)

Released December 15, 2021

No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording or any information storage and retrieval system, without the written permission of NCQA and IHA, except for the purposes of reporting quality data for the AMP programs or for internal quality improvement activities. © 2021 by the National Committee for Quality Assurance and Integrated Healthcare Association, all rights reserved.

Table of Contents

AMP Program Overview

Background.....	1
Changes to AMP Documentation for MY 2021	1
AMP Measurement.....	2
MY 2021 Measure Set and Product Lines for Reporting.....	3

AMP Program Information

AMP Commercial HMO Measurement and Reporting	6
AMP Commercial ACO Measurement and Reporting	6
AMP Medicare Advantage Measurement and Reporting	7
AMP Medi-Cal Managed Care Measurement and Reporting.....	7
Key Organizations Involved in Data Collection, Aggregation, and Reporting	7
Participation and Use of Results	8
Domains and Reporting Entities	10
Joining AMP as a New Plan	11
AMP General Program Timeline.....	12
AMP Data Collection and Reporting Timeline	12
Review and Correction of MY 2021 Results.....	15
What's in AMP MY 2021.....	16
Testing Measures	18

Overview

Background

IHA's Align. Measure. Perform. (AMP) programs are a nationally recognized source of trusted information on healthcare performance, enabling providers to track, and therefore improve, clinical quality, cost, and value. AMP consists of four programs, each focused on a specific population or product: Commercial HMO, Commercial ACO, Medicare Advantage and Medi-Cal Managed Care. Each AMP program uses a standardized measure set, established with the input of participating California provider organizations (POs) and health plans, to assess healthcare and health system performance. By providing a common measure set reflecting unified performance priorities across the healthcare industry, AMP programs allow participants to focus their performance measurement efforts on areas of particular importance. Each year, AMP delivers reliable performance results to its participants based on this common measure set, leading to improved health system processes, health outcomes, and reduced cost for millions of Californians. The measurement year (MY) 2021 Program Guide has been separated from the Technical Specifications, and presents detailed information on the AMP programs, programmatic updates unique to each measurement year, general participation guidance, and timelines.

Changes to AMP Documentation for MY 2021

IHA provides detailed programmatic and technical information to its participants to support accurate and complete data collection for the AMP programs. Historically, this information has been presented in the AMP Program Manual, which contained programmatic updates, reporting guidance, and technical specifications for all measures. In 2020, IHA's Technical Measurement and Program Governance Committees recommended an improved AMP program timeline beginning in MY 2021, which accelerates the release of measure specifications (in alignment with recent HEDIS timeline changes) and allows participating POs and health plans more time to apply specifications. In order to adapt to this new timeline and release relevant information on the AMP programs as soon as it is available, IHA has changed the presentation of programmatic guidelines (Program Guide **[this document]**) to be separate from measure specifications (Technical Specifications). The below table describes release dates for each of these documents.

	Previous Timeline (MY 2020 and prior)	Transition Timeline (MY 2021)	Future Timeline (MY 2022 and beyond)
Draft AMP Program Manual	September 1, 2020	September 1, 2020 (combined with MY 2020)	October 11, 2021 (Now referred to as AMP Technical Specifications)
Final AMP Program Manual	December 1, 2020	June 1, 2021 (Now referred to as AMP Technical Specifications)	June 1, 2022 (Now referred to as AMP Technical Specifications)
Preliminary AMP Program Guide (New)		June 1, 2021	June 1, 2022
Final AMP Program Guide (New)		December 15, 2021	December 15, 2022

Each document includes the following information:

- The *Draft MY 2020 and 2021 AMP Program Manual*, released on September 1, 2020, includes draft AMP programmatic information and draft technical specifications for all measures in the AMP program for MY 2020 and MY 2021, and reflects applicable changes in *HEDIS MY 2020 and 2021 Volume 2: Technical Specifications* (released in July 2020).

- The *MY 2020 Final AMP Program Manual*, released on December 1, 2020, includes final AMP programmatic information and final technical specifications for all measures in the AMP program for MY 2020, and reflects applicable changes in *HEDIS MY 2020 Volume 2: Technical Specifications Update* (released in October 2020).
- The *Final MY 2021 AMP Technical Specifications*, released on June 1, 2021, includes final technical specifications for all measures in the AMP program for MY 2021, and reflects applicable specification changes in *HEDIS MY 2021 Volume 2: Technical Specifications Update* (released in March 2021).
- The *Preliminary MY 2021 AMP Program Guide*, released on June 1, 2021, includes AMP programmatic information such as background on AMP programs, reporting guidance, timelines for data submission, and reflects applicable programmatic changes in *HEDIS MY 2021 Volume 2: Technical Specifications Update* (released in March 2021).
- The *Final MY 2021 AMP Program Guide*, released on December 15, 2021, includes all information previously included in the *Preliminary MY 2021 AMP Program Guide*, as well as additional AMP programmatic information which was not yet available in time for the release of the *Preliminary AMP Program Guide* on June 1, 2021.

AMP Measurement

The standardized AMP measure sets are intended to encourage best practices in clinical care, quality improvement, patient centeredness and use of resources, leading to better health outcomes for patients and the achievement of high-value care.

Measures in the AMP program are categorized into the following domains:

- Clinical Quality, with the following priority areas:
 - Cardiovascular
 - Diabetes
 - Musculoskeletal
 - Prevention and Screening
 - Maternity
 - Respiratory
 - Behavioral Health and Substance Use
- Data Quality
- Advancing Care Information
- Patient Experience
- Appropriate Resource Use
- Cost

MY 2021 Measure Set and Product Lines for Reporting

Domain	Priority Area	Measures	Commercial HMO	Commercial ACO	Medicare Advantage*	Medi-Cal Managed Care	Non-HEDIS® ¹	Differs From HEDIS	
Clinical Quality	Cardiovascular	Controlling High Blood Pressure	✓	✓	✓	✓		✓	
		Statin Therapy for Patients With Cardiovascular Disease	✓	✓	✓	✓		✓	
		Proportion of Days Covered by Medications—Renin Angiotensin System (RAS) Antagonists	✓		✓	✓	✓		
		Proportion of Days Covered by Medications—Statins	✓		✓	✓	✓		
	Diabetes	Proportion of Days Covered by Medications—Diabetes All Class	✓		✓	✓	✓		
		Comprehensive Diabetes Care—HbA1c Poor Control (9.0%)	✓	✓	✓	✓		✓	
		Comprehensive Diabetes Care—HbA1c Control (<8.0%)	✓			✓		✓	
		Comprehensive Diabetes Care—Eye Exam	✓	✓	✓	✓		✓	
		Comprehensive Diabetes Care—Nephropathy Monitoring	✓**	✓	✓	✓**		✓	
		Comprehensive Diabetes Care—BP Control (<140/90)	✓	✓		✓		✓	
		Comprehensive Diabetes Care—Optimal Diabetes Care Combination Rate	✓**			✓**	✓	✓	
		Comprehensive Diabetes Care—HbA1c Testing (One Test)				✓		✓	
		Statin Therapy for Patients With Diabetes	✓	✓		✓		✓	
		Statin Use in Persons with Diabetes			✓		✓		

¹HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

4 MY 2021 Measure Set and Product Lines for Reporting

Domain	Priority Area	Measures	Commercial HMO	Commercial ACO	Medicare Advantage*	Medi-Cal Managed Care	Non-HEDIS	Differs From HEDIS	
Clinical Quality	Musculoskeletal	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis			✓			✓	
		Osteoporosis Management in Women Who Had a Fracture			✓			✓	
	Prevention and Screening	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Documentation					✓		
		Child and Adolescent Well-Care Visits					✓		
		Childhood Immunization Status	✓	✓			✓		✓
		Immunizations for Adolescents	✓	✓			✓		
		Chlamydia Screening in Women	✓	✓			✓		
		Cervical Cancer Screening	✓	✓			✓		✓
		Cervical Cancer Overscreening	✓	✓			✓	✓	
		Breast Cancer Screening	✓	✓	✓		✓		✓
		Colorectal Cancer Screening	✓	✓	✓		✓		✓
	Maternity	Prenatal and Postpartum Care					✓**		
	Respiratory	Asthma Medication Ratio	✓	✓			✓		
		Appropriate Testing for Pharyngitis	✓	✓			✓		
		Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	✓	✓			✓		
Behavioral Health and Substance Use	Use of Opioids at High Dosage	✓**	✓**	✓**		✓**			
	Concurrent Use of Opioids and Benzodiazepines	✓	✓	✓**		✓	✓		
Data Quality	Data Quality	Encounter Rate by Service Type	✓**	✓**	✓**	✓**	✓		
		Encounter Format	✓**	✓**	✓**	✓**	✓		
		Encounter Timeliness	✓**	✓**	✓**	✓**	✓		

Domain	Priority Area	Measures	Commercial HMO	Commercial ACO	Medicare Advantage*	Medi-Cal Managed Care	Non-HEDIS	Differs From HEDIS
Advancing Care Information	Advancing Care Information	Controlling High Blood Pressure (e-Measure)	✓					
		Screening for Clinical Depression and Follow-Up Plan (e-Measure)	✓				✓	
Patient Experience	Patient Experience	Patient Experience/CG-CAHPS	✓			✓		✓
Appropriate Resource Use	Appropriate Resource Use	Ambulatory Care				✓		
		Frequency of Selected Procedures	✓**			✓**		✓
		Inpatient Utilization—General Hospital/Acute Care				✓		✓
		Generic Prescribing	✓			✓	✓	
		Outpatient Procedure Utilization—Percent Done in Preferred Facility	✓			✓	✓	
		All-Cause Readmissions (risk adjusted measure)	✓	✓	✓**	✓		✓
		Emergency Department Utilization (risk adjusted measure)	✓	✓				✓
		Acute Hospital Utilization (risk adjusted measure)	✓					✓
		Hospital Average Length of Stay	✓	✓		✓**	✓	
Cost	Cost	Total Cost of Care	✓	✓	✓**	✓	✓	

* All Medicare Advantage measures are used by CMS in their Stars Ratings program, except for Encounter Rate by Service Type, Encounter Format, Encounter Timeliness, Use of Opioids at High Dosage, Concurrent Use of Opioids and Benzodiazepines and Total Cost of Care.

**Measures collected for information only purposes; not recommended for use in incentive design or for public reporting.

AMP Program Information

AMP Commercial HMO Measurement and Reporting

Initiated in 2001, the AMP Commercial HMO program now includes participation from 11 health plans and about 200 California provider organizations caring for over 9.5 million Californians enrolled in Commercial HMO and point of service products—representing 90% of Commercial HMO enrollment in the state. AMP Commercial HMO has 4 key components: a common set of measures and benchmarks that span clinical quality, data quality, patient experience, utilization, and cost of care measures; value-based health plan incentive payments to provider organizations; public reporting of performance results for provider organizations; and public recognition awards. The AMP Commercial HMO program has demonstrated lasting and meaningful gains in quality performance, suggesting that a common performance measure set supports targeted improvement efforts.

The following plans are participating in the AMP Commercial HMO program in MY 2021:

- Aetna.
- Anthem Blue Cross.
- Blue Shield of California.
- Cigna Health Care of California.
- Health Net.
- Kaiser Permanente.
- LA Care Health Plan.
- Molina Healthcare.*
- Sharp Health Plan.
- Sutter Health Plus.
- UnitedHealthcare.
- Valley Health Plan.*
- Western Health Advantage.

*Participation of this plan in Audited Quality Data Submission for AMP Commercial HMO in MY 2021 is pending. Self-reporting POs should refer to the final MY 2021 Audited Data File Layouts (released in February 2022) to confirm whether to include members of this plan in reporting.

AMP Commercial ACO Measurement and Reporting

The AMP Commercial ACO program began as an effort to reduce clinician burden through standard, widespread adoption of common accountable care organization (ACO) performance measures and benchmarks by plans, purchasers, and provider organizations. IHA and the Purchaser Business Group on Health (PBGH) partnered to develop a standard measurement and benchmarking program for Commercial ACOs across the nation. The measure set is highly aligned with other key measurement programs and focused on innovative and meaningful new measures, such as patient reported outcomes.

IHA's Program Governance Committee (PGC) made a strategic recommendation to restructure the AMP Commercial ACO program starting in MY 2021. In this new structure, IHA will no longer require provider ACO-level results reporting, and will focus more on providing insights to the industry on ACO performance and characteristics across California. IHA will continue to collect and monitor ACO performance through health plan data submission. Provider organizations will no longer need to submit self-reported data for the AMP Commercial ACO program beginning in MY 2021.

The following plans are participating in the AMP Commercial ACO program in MY 2021:

- Aetna.
- Anthem Blue Cross.
- Blue Shield of California.
- Health Net.
- Oscar Health Plan.
- UnitedHealthcare.

AMP Medicare Advantage Measurement and Reporting

AMP Medicare Advantage was prompted by the introduction of the Centers for Medicare & Medicaid Services (CMS) Star Rating incentive program for Medicare Advantage health plans. While CMS's Star Rating program measures performance and assigns Star ratings at the plan level, AMP Medicare Advantage participants felt that measuring the same indicators and assigning Star ratings at the PO level would support quality improvement.

AMP Medicare Advantage uses the same measures (when applicable) and Star Rating methodology used by CMS for its health plan Star ratings. Measure results are collected, aggregated, and reported at the PO level using the same data collection and audit process used in the Commercial HMO program, and IHA calculates PO-level Star Ratings for use in IHA recognition awards and public reporting through the California Office of the Patient Advocate's Medicare Advantage Medical Group Report Card. While health plans may choose to use the results as the basis of performance incentive payments, no standard incentive design for AMP Medicare Advantage currently exists.

The following plans are participating in the AMP Medicare Advantage program in MY 2021:

- Blue Shield of California.
- Health Net.
- Inter Valley Health Plan.
- Kaiser Permanente.
- Sharp Health Plan.
- UnitedHealthcare.
- Western Health Advantage.

AMP Medi-Cal Managed Care Measurement and Reporting

With 11 million of 13 million Medi-Cal enrollees receiving care through managed care plans, and with an increasing overlap in provider networks across insurance product types, aligned, consistent, and comparative performance measurement is critical. AMP Medi-Cal Managed Care intends to align measurement across health plans and provider organizations providing care to Medi-Cal Managed Care members. AMP Medi-Cal Managed Care implements a standard measure set across participating health plans and provider organizations. Measure results are collected, aggregated and reported at the PO level using IHA's data collection processes. Medi-Cal Managed Care plans may use the results as the basis of performance incentive payments.

The following plan is participating in the AMP Medi-Cal Managed Care program in MY 2021:

- Blue Shield of California Promise Health Plan.

Only POs contracted with Blue Shield of California Promise Health Plan may self-report for the AMP Medi-Cal Managed Care program for MY 2021.

Key Organizations Involved in Data Collection, Aggregation, and Reporting

IHA The **Integrated Healthcare Association** manages the AMP programs and convenes all relevant committees. IHA arranges for all necessary services, including measure development, data aggregation, and publication of the results in a public report card.

NCQA The **National Committee for Quality Assurance** develops and maintains the measures and audit methodologies and evaluates and collects data for the Advancing Care Information domain. The majority of clinical quality measures are adapted from the NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measures, the most widely used set of performance measures in the managed care industry. Non-HEDIS measures are noted in the specifications. NCQA is a nonprofit

organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

PBGH The **Purchaser Business Group on Health** administers the Patient Assessment Survey (PAS), which is used to measure performance in the Patient Experience domain of AMP Commercial HMO and AMP Medi-Cal Managed Care. PBGH reports relevant PAS results to IHA for inclusion in AMP reports.

PBGH is also a partner in the launch of AMP Commercial ACO.

TransUnion HealthCare **TransUnion HealthCare** (formerly the Diversified Data Design Corporation, a subsidiary of TransUnion LLC), helps IHA collect clinical data from POs and health plans.

Onpoint Health Data (Onpoint) **Onpoint Health Data** helps develop and maintain the non-HEDIS Appropriate Resource Use (ARU) and Total Cost of Care (TCOC) measures; collects and standardizes claims, encounter, eligibility, pharmacy, and cost data from health plans; aggregates data across health plans for each PO and calculates the ARU and TCOC measures; and creates reports for all parties. Onpoint also generates select **quality** measures **based on claims data submitted by health plans** in the **AMP** programs.

OPA The **Office of the Patient Advocate** is an independent state office created to represent the interests of health plan members in getting the care they deserve and to promote transparency and quality health care. OPA uses AMP Commercial HMO and Medicare Advantage results as the basis of its annual Medical Group Quality of Care Report Cards, at <http://www.opa.ca.gov>.

Participation and Use of Results

All POs in California are eligible to participate in IHA's AMP programs—regardless of specialty or geographic area. To participate, POs must contract with one or more of the health plans participating in the appropriate AMP program and sign a Consent Agreement. No data is reported for POs that have not signed a Consent Agreement.

All AMP programs include a standard measure set, which can include measures across the six domains of AMP measurement: Clinical Quality, Data Quality, Advancing Care Information, Patient Experience, Appropriate Resource Use, and Cost Domains use these data sources:

- *Clinical Quality Domain results* are calculated and submitted by health plans contracting with each PO, and/or by self-reporting POs, unless otherwise stated in the specifications.
- *Data Quality Domain* includes measures focused on improving the transmission of encounter data between POs and plans. Measures in this domain include encounter data volume, encounter format, and encounter data timeliness.
- *Advancing Care Information Domain data* are voluntarily submitted by POs.
- *Patient Experience Domain data* are collected via the Patient Assessment Survey (PAS) and processed by the Center for the Study of Systems (CSS).
- *Appropriate Resource Use Domain* and *Cost Domain results* are calculated by Onpoint using data submitted by health plans contracting with each PO, unless otherwise stated in the specifications. The Appropriate Resource Use Domain includes the Appropriate Resource Use measures. The Cost domain includes the Total Cost of Care measure.

See the [MY 2021 AMP Measure Set](#) for more information.

Measure results for each PO are aggregated across participating health plans and can be used as the basis for individual program components such as health plan incentive payments, public reporting, and public recognition awards.

AMP Program	Participant Reporting/Benchmarking	Health Plan Incentive Payments	Public Reporting	Public Recognition
Commercial HMO	✓	✓	✓	✓
Commercial ACO	✓	Optional	NA	NA
Medicare Advantage	✓	Optional	✓	✓
Medi-Cal Managed Care	✓	Optional	NA	NA

IHA seeks to ensure that the AMP measure set continues to provide stakeholders with the most relevant, meaningful, valuable, and effective information on health care quality and resource use, and that it does so in the most efficient way possible.

The [2016–2021 Measure Set Strategy](#) guides development and maintenance of the AMP measure sets. Key priorities identified in the measure set strategy include supporting alignment across commonly used measure sets, targeted development of the AMP measure set, and reducing the burden of data collection and reporting. IHA also hosts an annual public comment period in October and participants and industry stakeholders are encouraged to provide input on AMP measurement for consideration by the stakeholder-led committees governing the AMP programs.

Data Sharing

The AMP programs encourage data sharing between POs and health plans; however, IHA staff are not prescriptive about how this is done. POs and health plans are expected to work together early in the process to establish a data sharing process and requirements. This may include an agreement on allowable data types, file formatting, timing, and confirmation of data received and of data used in health plan reports.

Domains and Reporting Entities

Domain	Health Plans Report	POs Voluntarily Self-Report	CSS/PBGH	Onpoint
Clinical Quality	✓	✓		✓*
Data Quality	✓			✓*
Advancing Care Information		✓		
Patient Experience		✓**	✓	
Appropriate Resource Use				✓
Cost				✓

*Onpoint will generate the HDO, COB, and SUPD measures from the submitted pharmacy claims data. Onpoint will generate the Encounter Format and Encounter Timeliness measures in the Data Quality Domain.

**POs voluntarily participate in the Patient Experience Domain and must register with PAS to receive results in this domain.

PO self-reporting in the AMP programs is entirely optional. Self-reporting POs participating in more than one AMP program are not required to self-report for all programs; however, when self-reporting for any of the AMP programs, a self-reporting PO must include all data on behalf of its contracted, participating plans when submitting results.

Self-Reporting Example 1: PO A is participating in AMP Commercial HMO and Medicare Advantage. PO A chooses to self-report results in AMP Commercial HMO, but not in Medicare Advantage. When self-reporting Commercial HMO results, PO A must include data from all contracted, participating health plans in the Commercial HMO product line.

Self-Reporting Example 2: PO B participates in AMP Commercial HMO and AMP Medi-Cal Managed Care and wants to self-report for both programs. PO B has contracts with three Commercial plans, Plan C1, Plan C2, Plan C3 and will self-report data for all three contracted Commercial HMO plan members. PO B has contracts with two Medi-Cal plans, Blue Shield of California Promise and Plan M2 (not participating in AMP Medi-Cal Managed Care). PO B will only self-report data for Blue Shield of California Promise members, as they are the only Medi-Cal plan participating in AMP Medi-Cal Managed Care.

The following health plans are participating in the AMP programs in MY 2021:

Health Plan	AMP Commercial HMO	AMP Commercial ACO	AMP Medicare Advantage	AMP Medi-Cal Managed Care
Aetna	✓	✓		
Anthem Blue Cross	✓	✓		
Blue Shield of California	✓	✓	✓	
Blue Shield of California Promise				✓
Cigna Health Care of California	✓			
Health Net	✓	✓	✓	
Inter Valley Health Plan			✓	
Kaiser Permanente	✓		✓	
LA Care Health Plan	✓			

Health Plan	AMP Commercial HMO	AMP Commercial ACO	AMP Medicare Advantage	AMP Medi-Cal Managed Care
Molina Healthcare*	✓*			
Oscar Health Plan		✓		
Sharp Health Plan	✓		✓	
Sutter Health Plus	✓			
UnitedHealthcare	✓	✓	✓	
Valley Health Plan*	✓*			
Western Health Advantage	✓		✓	

*Participation of this plan in Audited Quality Data Submission for AMP Commercial HMO in MY 2021 is pending. Self-reporting POs should refer to the final MY 2021 Audited Data File Layouts (released in February 2022) to confirm whether to include members of this plan in reporting.

Health plans and POs that choose to use a vendor to calculate their AMP program results must use an NCQA-Certified vendor.

Health plans and POs that run their own measure results (without using a vendor) **must** contract directly with NCQA and use NCQA’s test-deck process to certify their measure logic using NCQA’s automated source code review (ASCR) program.

A complete list of current vendors is available [here](#) for health plans and POs interested in contracting with an NCQA-Certified vendor.

Review frequently asked questions [about measure certification for AMP here](#).

Joining AMP as a New Plan

New plans that want to join an AMP program should send an email to amp@iha.org. IHA staff can provide plans with estimated participation costs. Plans must contract with an organization licensed by NCQA to conduct HEDIS and AMP compliance audits. A list of NCQA-Certified HEDIS and AMP audit Licensed Organizations is available [here](#).

Plans can download the **Preliminary Health Plan Clinical and Testing Measure File Layouts (January)** and **Final Health Plan Clinical and Testing Measure File Layouts (February)** from the [IHA website](#) and submit their audited data files to TransUnion according to the timeline specified in this section.

Plans will also need to sign a Health Plan Participation Agreement with IHA and a Business Associate Agreement with Onpoint. IHA staff will put new plans in touch with Onpoint staff.

AMP General Program Timeline

The timeline below includes information on general program activities and milestones for MY 2021.

General Program Dates

Activity or Milestone	PO Deadline	Health Plan Deadline
Medication List Directory (MLD): MY 2021 MLD posted to NCQA website .	March 31, 2021	
Final MY 2021 Technical Specifications, and Preliminary MY 2021 Program Guide posted to the IHA website.	June 1, 2021	
2021 Public Comment Period posted to the IHA website. <ul style="list-style-type: none"> • Call for Public Comment document for MY 2022 • Draft AMP MY 2022 Technical Specifications • MY 2022 Proposed Measure Sets 	October 11–October 31, 2021	
PAS: Registration information emailed to POs.	September 24, 2021	
MY 2021 Participation Confirmation Period: POs declare their intent to participate in the AMP programs for MY 2021 and confirm their health plan contracts.	November 2021–December 2021	November 2021–December 2021
Audit Guidelines: MY 2021 AMP Audit Guidelines posted to NCQA and IHA website.	November 1, 2021	
Final MY 2022 Measure Set posted to the IHA website.	December 15, 2021	
Final MY 2021 AMP Program Guide posted to the IHA website.	December 15, 2021	
2021 Public Comment Responses posted to the IHA website.	December 15, 2021	
Final AMP Master from Participation Confirmation distributed to AMP data partners.	February 1, 2022	

AMP Data Collection and Reporting Timeline

The timelines below include major milestones for MY 2021 in the Clinical Quality, Data Quality, Appropriate Resource Use, and Total Cost of Care data collection and reporting processes. They ensure that data are as complete as possible, as early as possible, to maximize administrative reporting for the AMP programs.

Health Plan and PO Quality Data Submission (to TransUnion HealthCare)

Activity or Milestone	PO Deadline	Health Plan Deadline
Data Submission File Layout: MY 2021 data submission file layout posted to IHA website. AMP participants will be notified of the most recent postings through AMP communications such as the monthly newsletters.	Preliminary File: January 17, 2022 Final File: February 14, 2022	
Q1-Q4 Encounter Data: POs that use TransUnion HealthCare as the encounter data intermediary must submit all remaining Q4 2021 encounter data to TransUnion HealthCare. POs that use a different data intermediary or supply encounters directly to health plans should confirm the final acceptance date of encounter data to be included in reporting.	February 11, 2022	NA
Supplemental Data Collection Deadline: Organization completes and stops all nonstandard supplemental data collection and entry.	February 11, 2022	March 1, 2022

Activity or Milestone	PO Deadline	Health Plan Deadline
Measure Certification Deadline: Final date for vendors to earn AMP Measure Certification to demonstrate that coded measures meet current NCQA standards and produce accurate and comparable results.	November 1, 2021	
Supplemental Data Validation Deadline <ul style="list-style-type: none"> • For POs: Auditor finalizes approval of <i>all</i> supplemental data for POs. Primary source verification (PSV) for nonstandard supplemental data must not occur prior to February 11, unless the PO finished all supplemental data processes, collection and entry. • For Health Plans: Auditor finalizes approval of <i>all</i> supplemental data for health plans. Primary source verification (PSV) for nonstandard supplemental data must not occur prior to February 28, unless the health plan finished all supplemental data processes, collection and entry. 	March 11, 2022	March 31, 2022
Organization submits preliminary rates to the auditor for review. <i>Auditors should review preliminary rates based on the current year's specifications.</i>	March 25, 2022	
Supplemental Data to Health Plans: Health plans receive the audited supplemental data files and audit results from the PO.	March 31, 2022	
Data Layout Test Files: Self-reporting POs and health plans submit data layout test files to TransUnion HealthCare.	March 21–April 25, 2022	
Self-Reporting PO review period: Self-reporting POs review all submissions before sending to auditors to ensure data validity and completeness. <i>Note: IHA will not accept requests for appeal of corrections to a PO's self-reported data during the appeals process. Please review your organization's submission of self-reported results to ensure it is complete and correct before sending it to your auditor and to TransUnion.</i>	April 18–April 25, 2022	NA
Submission Files to Auditors: Self-reporting POs and health plans send submission files to auditors.	April 25, 2022	
Auditor-Locked Results: Self-reporting POs and health plans submit auditor-locked clinical results to TransUnion. Health plans must submit results for all clinical measures for each contracted PO with a signed AMP Consent Agreement. Advancing Care Information (non-audited): Non-Self-reporting POs reporting the Advancing Care Information e-Measures must also submit by this date.	May 6, 2022	
Resubmission of Auditor-Locked Results: Self-reporting POs and health plans submit auditor-locked clinical results to TransUnion HealthCare, if needed.	July 15, 2022	

Health Plan Claims and Encounter Data Submission (to Onpoint Health Data)

Activity or Milestone	Health Plan Deadline by Data Type					
	Eligibility	Medical Claims	Pharmacy Claims	Member Identifier	Cost	Lab Results
Q1 2021 Data Submission: Production file received by Onpoint: Monthly eligibility between January 1 and March 31, 2021, and all claims paid or changed through March 31, 2021, not previously submitted.	April 30, 2021	April 30, 2021	April 30, 2021		April 30, 2021	April 30, 2021
Q2 2021 Data Submission: Monthly eligibility and all claims paid or changed between April 1 and June 30, 2021.	July 30, 2021	July 30, 2021	July 30, 2021		July 30, 2021	July 30, 2021
Q3 2021 Data Submission: Monthly eligibility and all claims paid or changed between July 1 and September 30, 2021.	October 29, 2021	October 29, 2021	October 29, 2021		October 29, 2021	October 29, 2021
Q4 2021 Data Submission: Monthly eligibility and all claims paid or changed between October 1 and December 31, 2021.	January 31, 2022	January 31, 2022	January 31, 2022		January 31, 2022	January 31, 2022
Q1 2022 Data Submission: Production file received by Onpoint: Monthly eligibility between January 1 and March 31, 2022 and all claims paid or changed through March 31, 2022.	April 29, 2022	April 29, 2022	April 29, 2022		April 29, 2022	April 29, 2022
Annual File Submission: Production file received by Onpoint: Eligible members enrolled for at least one day between January 1 and December 31, 2021 who are also included in eligibility file submissions (no continuous enrollment criteria apply).				April 29, 2022		
Annual File Submission: Production file received by Onpoint: Cost results pertaining to services paid or changed between January 1 and March 31, 2022.					May 13, 2022	
MY 2021 Validation Report to Plan.	June 28, 2022	June 28, 2022	June 28, 2022	June 28, 2022	June 28, 2022	
MY 2021 Plan Validation & Sign-Off.	July 15, 2022	July 15, 2022	July 15, 2022	July 15, 2022	July 15, 2022	

AMP Report Release Dates and Review Periods

Activity or Milestone	Time Frame or Deadline
QUALITY RESULTS REPORTING TIMELINE	
Preliminary AMP Quality Reports Release: IHA posts preliminary quality reports for POs and health plans. Quality reports include results from measures based on health plan and/or PO clinical submissions as specified in the AMP measure sets.	May 27, 2022
AMP Quality Questions and Appeals Period: IHA staff work with POs and health plans to address any data issues or questions related to quality results. Plans and POs may submit an appeal during this time.	May 27–June 17, 2022
AMP Quality Appeals Hearing: The Appeals Panel reviews and decides on all appeals to change quality results, if needed.	June 29, 2022
Resubmission of Auditor-Locked Results: Self-reporting POs and health plans submit auditor-locked clinical results to TransUnion HealthCare, if needed.	July 15, 2022
Final AMP Quality Reports Released: IHA releases final quality reports to POs and health plans. Quality reports include results from measures based on health plan and/or PO clinical submissions as specified in the AMP measure sets.	August 9, 2022
ONPOINT GENERATED RESULTS REPORTING TIMELINE	
Preliminary AMP Onpoint-generated Reports Released: IHA posts preliminary Onpoint-generated reports for POs and health plans. Onpoint-generated reports include results from measures based on health plan claims submissions as specified in the AMP measure sets.	August 9, 2022
AMP Onpoint-generated Questions and Appeals Period: IHA and Onpoint work with POs and health plans to address any questions or issues related to the Onpoint-generated results for the AMP programs.	August 10–30, 2022
AMP Onpoint-generated Appeals Hearing: The Appeals Panel reviews and decides on all appeals to change results, if needed.	September 16, 2022
Final Reports Released: IHA releases final reports to POs and health plans. Final reports include results from both the Quality and Onpoint-generated releases across all AMP programs specified in the AMP measure sets. <i>Note: Timeline assumes resolution of appeals do not require data resubmissions. If a data resubmission is required, a revised timeline will be communicated to participants.</i>	October 14, 2022

Review and Correction of MY 2021 Results

IHA is committed to providing POs and health plans an opportunity to review their AMP results and to submit questions and requests for changes if they believe any of their results are in error.

The full timeline for reviewing AMP results and requesting corrections or changes is documented in the *Data Collection and Reporting Timeline* above. IHA staff encourage participants to seek corrections and additional information throughout the measurement cycle.

Organizations have 15 business days to review preliminary results. Corrections or changes to results may be requested from the first date when the PO Preliminary Reports become available, through the last date of the Results Questions and Appeals Periods. Detailed instructions on how to submit a question or request an appeal will be provided before each Questions and Appeals Period.

- **Preliminary Quality Reports** are released on **May 27, 2022**, and the final date to submit an appeal is **June 17, 2022**. IHA staff work with health plans and vendors to research and respond to PO questions about results provided in the PO Preliminary Quality Reports.
- **Preliminary Onpoint-generated Reports** are released on **August 9, 2022**, and the final date to submit an appeal is **August 30, 2022**. IHA staff work with health plans to answer PO questions about results provided in the PO Preliminary Onpoint-generated Reports.

Based on the findings and answers in response to a results inquiry, an organization may submit an appeal at any time during the results Questions and Appeals Period if they believe an error has been made. The burden of evidence is on the organization submitting the appeal. A multi-stakeholder Appeals Review Panel will consider the evidence and make a binding determination on the appeal. POs and health plans must comply with the determination of the Appeals Review Panel, including resubmission of data, if necessary. No further reconsideration is granted.

The Appeals Panel is made up of seven members: three representatives from participating health plans, three representatives from participating provider organizations, and one at-large member. The panel receives blinded appeal requests, supporting documentation and a summary from IHA describing the source and reason for possible error, the scope of the change requested and a recommendation for resolution. Each appeal is voted on by the Appeals Panel. All results are final after the close of the Appeals Period. It will not be possible to resolve errors raised after the close of the Appeals Period.

The AMP programs require a firm deadline to finalize results for all participants and share them with health plans for use in program deliverables such as health plan incentive payments, PO recognition, and public reporting. Although late requests for additional data submission or reconsideration of results will be acknowledged, they will not be incorporated into the report. An exception may be made if the data aggregator (IHA or Onpoint) made an error that was discovered after the deadline.

Throughout the measurement cycle, participants can request additional information or clarification on program processes and methodology.

What's in AMP MY 2021

Clinical Quality Domain

The AMP Clinical Quality domain includes both HEDIS based and non-HEDIS based measures for measurement at the PO level. Health plans and self-reporting POs report data for nearly all of the measures in the Clinical Quality domain via the audited results submission to TransUnion. Each participating health plan submits Clinical Quality results for each of its contracted POs **for each AMP program listed within the Health Plan Audited Clinical Data File Layouts**. **Select** Clinical Quality results are generated **from** the health plan claims submission to Onpoint **per measure specifications**. POs may also voluntarily self-report their own clinical results for one or more clinical measures. POs are allowed to self-report for all **applicable** AMP programs **as specified in the PO Audited Clinical Data File Layouts**.

All clinical results submitted to TransUnion must be audited to ensure that results are an accurate reflection of PO performance (with the exception of AMP Commercial ACO results, for which an audit process does not yet exist). Audit review of the clinical measures is based on NCQA's HEDIS Compliance Audit™ program. NCQA staff work with AMP participants to incorporate the relevant components of the HEDIS Compliance Audit, adapt policies and procedures where necessary and enhance the process based on previous years' experience. Because this program is an adaptation, it is considered an AMP program audit review. The *MY 2021 AMP Audit Review Guidelines* **are** available [here](#).

IHA aggregates data across health plans and reports the data alongside data from self-reporting POs (where applicable). IHA selects and reports the higher rate (health plan aggregate or PO self-reported)

for each measure when used in health plan incentive payments, public reporting, and/or public recognition awards. IHA applies a minimum denominator threshold of 30 for clinical measures used in benchmarking, incentive payments, public reporting and/or public recognition awards.

Refer to *Clinical Quality Domain Technical Specifications* for a list of measures.

Advancing Care Information Domain

This domain evaluates PO adoption and use of healthcare IT, such as electronic health records (EHR). The Advancing Care Information domain measures the providers' ability to generate clinical e-measure results directly from their EHR systems. POs may voluntarily participate in the domain by submitting e-measure results in their clinical file submission to TransUnion.

Refer to *Advancing Care Information Domain Technical Specifications* for a list of measures.

Patient Experience Domain

The survey used to collect data for the Patient Experience Domain is the national standard CAHPS^{®2} Clinician & Group (CG-CAHPS) Patient Experience Survey endorsed by the National Quality Forum (NQF). The CG-CAHPS was developed by the Agency for Healthcare Research and Quality (AHRQ) and its research partners in the CAHPS consortium. PBGH oversees the CG-CAHPS survey for California POs, called the Patient Assessment Survey (PAS), for POs that choose to participate.

POs voluntarily participate in the Patient Experience domain through the PAS survey; health plans do not submit data for this domain.

Refer to *Patient Experience Domain Technical Specifications* for a list of measures.

Data Quality Domain

The Data Quality Domain includes measures focused on improving the transmission of encounter data between POs and plans. Measures in this domain include encounter data volume, which is calculated and submitted by health plans contracting with each PO, and encounter data timeliness and format, which are calculated by Onpoint.

Refer to *Data Quality Domain Technical Specifications* for a list of measures.

Appropriate Resource Use Domain

This domain assesses use of key health care services to identify variation and maximize limited resources. Health plans submit claims, encounter, eligibility, pharmacy and cost data to Onpoint, which calculates the measures in the Appropriate Resource Use Domain; POs and health plans do not report measures in this domain.

Beginning in MY 2013, the *All-Cause Readmissions* measure was approved for public reporting (for applicable AMP programs). All other Appropriate Resource Use results are not publicly reported but may be used by health plans as the basis for performance incentives. For utilization measures, IHA applies a minimum denominator threshold of 360 member-months for health plan performance incentives. For risk adjusted utilization measures (with the exception of the *All-Cause Readmissions* measure), IHA applies a minimum denominator threshold of 150 for health plan performance incentives. For the *All-Cause Readmissions* measure specifically, IHA applies a minimum denominator threshold of 30 for public reporting.

Refer to *Appropriate Resource Use Domain Technical Specifications* for a list of measures.

²CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Cost Domain

This domain assesses the total amount paid to care for all members of a PO for a year, including professional, pharmacy, hospital, and ancillary services and consumer cost-sharing. Health plans submit claims, encounter, eligibility, pharmacy and cost data to Onpoint to calculate the Cost Domain; POs and health plans do not report this domain.

Beginning in MY 2014, the *Total Cost of Care* measure was approved for public reporting (for applicable AMP programs). IHA applies a minimum denominator threshold of 200 member-years to the *Total Cost of Care* measure for public reporting.

Refer to the *Cost Domain Technical Specifications* for more information on this measure.

Testing Measures

The AMP measure set includes testing measures for voluntary data collection and submission. IHA uses testing measure results to evaluate measures for future inclusion in the measure set. There is opportunity for Public Comment before testing measures are finalized by the Technical Measurement and **Program** Governance Committees.

There are no testing measures for MY 2021.

Clinical	None.
Data Quality	None.
Advancing Care Information	None.
Patient Experience	None.
Appropriate Resource Use	None.
Cost	None.