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

Measurement Year 2023 Program Guide (Final)

Released December 15, 2023

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AMP Program 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 three programs, each focused on a specific population or product: Commercial HMO, Medicare Advantage and Medi-Cal Managed Care.[1] 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) 2023 Program Guide 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 2023

IHA provides detailed programmatic and technical information to its participants to support accurate and complete data collection for the AMP programs. Programmatic guidelines are included in the AMP Program Guide **[this document]**, and the measure specifications are included in the AMP Technical Specifications.

Each document is listed below and includes the following information:

- The *Draft MY 2023 AMP Technical Specifications*, released on October 10, 2022, includes draft technical specifications for all measures in the AMP program for MY 2023, and reflects applicable changes in *HEDIS* ®[2] *MY 2023 Volume 2: Technical Specifications* (released in August 2022).
- The *Final MY 2023 AMP Technical Specifications,* released on June 1, 2023, includes final technical specifications for all measures in the AMP program for MY 2023, and reflects applicable changes in *HEDIS MY 2023 Volume 2: Technical Specifications Update* (released in March 2023).
- The *Preliminary MY 2023 AMP Program Guide,* released on June 1, 2023, includes AMP programmatic information such as background on AMP programs, reporting guidance, and timelines for data submission.
- The *Final MY 2023 AMP Program Guide*, released on December 15, 2023, includes all information previously included in the *Preliminary MY 2023 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, 2023.

[1] IHA no longer reports PO-level results for Commercial ACOs as part of the AMP program.
[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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
- Patient Experience
- Appropriate Resource Use
- Cost

MY 2023 Measure Set and Product Lines for Reporting

Domain	Priority Area	Measures	Commercial HMO	Medicare Advantage*	Medi-Cal Managed Care	Non-HEDIS	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	✓	✓	✓	✓	
		Hemoglobin A1c Control for Patients with Diabetes: HbA1c control <8.0%	✓		✓		✓
		Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c control >9.0%	✓	✓	✓		✓
		Blood Pressure Control for Patients with Diabetes	✓		✓		✓
		Eye Exam for Patients with Diabetes	✓	✓	✓		✓
		Kidney Health Evaluation in Patients with Diabetes	✓	✓	✓		✓
		Statin Therapy for Patients With Diabetes	✓		✓		✓
		Statin Use in Persons with Diabetes		✓		✓	
	Musculoskeletal	Osteoporosis Management in Women Who Had a Fracture		✓			✓
	Prevention and Screening	Child and Adolescent Well-Care Visits	✓		✓		
		Childhood Immunization Status	✓		✓		✓
		Immunizations for Adolescents	✓		✓		
		Chlamydia Screening in Women	✓		✓		
		Cervical Cancer Screening	✓		✓		✓
		Cervical Cancer Overscreening	✓		✓	✓	

Domain	Priority Area	Measures	Commercial HMO	Medicare Advantage*	Medi-Cal Managed Care	Non-HEDIS	Differs From HEDIS
		Breast Cancer Screening (ECDS measure)	✓	✓	✓		✓
		Colorectal Cancer Screening	✓	✓	✓		✓
	Maternity	Prenatal and Postpartum Care	✓***		✓		
		Prenatal Immunization Status (ECDS measure)	✓		✓		
	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	✓**	✓**	✓**	✓	
Patient Experience	**Patient Experience**	Patient Experience/CG-CAHPS	✓		✓		✓
Appropriate Resource Use	**Appropriate Resource Use**	Ambulatory Care			✓		
		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	✓**		✓**	✓	

Domain	Priority Area	Measures	Commercial HMO	Medicare Advantage*	Medi-Cal Managed Care	Non-HEDIS	Differs From HEDIS
Cost	**Cost**	Total Cost of Care	✓	✓**	✓	✓	
Testing	**Testing**	Depression Screening and Follow-up for Adolescents and Adults (ECDS measure)	✓***		✓***		
		Transitions of Care: Medication Reconciliation Post-Discharge		✓***			
		Well Child Visits in the First 30 Months of Life	✓***		✓***		

* 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.

***Measures added to MY 2023 for testing in respective product lines.

AMP Program Information

AMP Commercial HMO Measurement and Reporting

Initiated in 2001, the AMP Commercial HMO program now includes participation from 12 health plans and about 200 California POs caring for over 9.5 million Californians enrolled in Commercial HMO and point of service products—representing 95% 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 POs; 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 2023:

- 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.
- Western Health Advantage.

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 Center for Data Insights and Innovation'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 2023:

- Blue Shield of California.
- Kaiser Permanente.
- Sharp Health Plan.
- SCAN Health Plan. (NEW)
- UnitedHealthcare.
- Wellcare by Health Net.
- 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 POs providing care to Medi-Cal Managed Care members. AMP Medi-Cal Managed Care implements a standard measure set across participating health plans and POs. 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 plans are participating in the AMP Medi-Cal Managed Care program in MY 2023:

- Blue Shield of California Promise Health Plan.
- Inland Empire Health Plan.

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. 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.

FinThrive HealthCare, Inc. **FinThrive HealthCare, Inc.** (formerly TransUnion Healthcare) 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 hosts the Performance Reporting Portal through which all AMP results are released to participants. Onpoint also generates select quality measures based on claims data submitted by health plans in the AMP programs.

CDII The **Center for Data Insights and Innovation** is an independent California state office created to improve the lives of all Californians by turning data into insights, knowledge, and equitable action. CDII uses AMP Commercial HMO and Medicare Advantage results as the basis of its annual Medical Group Health Care Quality Report Cards. The Office of the Patient Advocate (OPA) moved to CDII in October 2021.

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 five domains[3] of AMP measurement: Clinical Quality, Data Quality, 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.
- *Patient Experience Domain data* are collected via the 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 2023 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	✓	✓	✓	✓
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. 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.

[3] The Advancing Care Information Domain was retired for MY 2023. Self-reporting POs are no longer required to submit results for measures in the Advancing Care Information Domain.

Domains and Reporting Entities

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

*The Clinical Quality Domain includes three testing measures for MY 2023: Depression Screening and Follow-Up for Adolescents and Adults, Transitions of Care, and Well-Child Visits in the First 30 Months of Life. A fourth measure – Prenatal and Postpartum Care – is included for testing in the Commercial HMO product line. All health plans and self-reporting POs are strongly encouraged to report testing measure results.

**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, and 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 contracted with PO B participating in AMP Medi-Cal Managed Care.

The following health plans are participating in the AMP programs in MY 2023:

Health Plan	AMP Commercial HMO	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	✓		
Inland Empire Health Plan			✓
Kaiser Permanente	✓	✓	
LA Care Health Plan	✓		
Molina Healthcare	✓		

Health Plan	AMP Commercial HMO	AMP Medicare Advantage	AMP Medi-Cal Managed Care
SCAN Health Plan		✓	
Sharp Health Plan	✓	✓	
Sutter Health Plus	✓		
UnitedHealthcare	✓	✓	
Wellcare by Health Net		✓	
Western Health Advantage	✓	✓	

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.

Joining AMP as a New Plan or Initiating PO Self-Reporting

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. New plans are required to follow the same audit and certification requirements as existing plans. 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 the Final Health Plan Clinical and Testing Measure File Layouts (February) from the IHA website and submit their audited data files to FinThrive HealthCare, Inc. according to the timeline specified in the section below.

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.

POs that intend to self-report in the coming year should indicate this in the annual Participation Confirmation period. POs can download the Provider Organization Clinical and Testing Measure File Layouts from the IHA website in the "Data Collection and Submission Resources" section.

Plans and POs that choose to use a vendor to calculate their AMP program results must use an NCQA-Certified vendor. Plans and POs that run their own measure results (without using a vendor) must contract directly with NCQA and use NCQA's ASCR process to certify their measure logic.

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

AMP General Program Timeline

The timeline below includes information on general program activities and milestones for MY 2023.

General Program Dates

Activity or Milestone	PO Deadline	Health Plan Deadline
Medication List Directory (MLD): MY 2023 MLD posted to NCQA website.	March 31, 2023	
Final MY 2023 Technical Specifications, and Preliminary MY 2023 Program Guide posted to the IHA website.	June 1, 2023	
2023 Public Comment Period posted to the IHA website. • Call for Public Comment document for MY 2024 • Draft AMP MY 2024 Technical Specifications • MY 2024 Proposed Measure Sets	October 9–October 27, 2023	
PAS: Registration information emailed to POs.	September 22, 2023	
MY 2023 Participation Confirmation Period: POs declare their intent to participate in the AMP programs for MY 2023 and confirm their health plan contracts.	November 9–November 29, 2023	
Audit Guidelines: MY 2023 AMP Audit Guidelines posted to NCQA and IHA website.	November 1, 2023	
Final MY 2024 Measure Set posted to the IHA website.	December 15, 2023	
Final MY 2023 AMP Program Guide posted to the IHA website.	December 15, 2023	
2023 Public Comment Responses posted to the IHA website.	December 15, 2023	
Final AMP Master from Participation Confirmation distributed to AMP data partners.	February 2, 2024	

AMP Data Collection and Reporting Timeline

The timelines below include major milestones for MY 2023 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 FinThrive HealthCare, Inc.)

Activity or Milestone	PO Deadline	Health Plan Deadline
Data Submission File Layout: MY 2023 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 16, 2024 **Final File:** February 12, 2024	
Q1-Q4 Encounter Data: POs that use FinThrive HealthCare, Inc. as the encounter data intermediary must submit all remaining Q4 2023 encounter data to FinThrive HealthCare, Inc. 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 9, 2024	NA
Supplemental Data Collection Deadline: Organization completes and stops all nonstandard supplemental data collection and entry.	February 9, 2024	March 1, 2024

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.	September 1, 2023	
Supplemental Data Validation Deadline • **For POs:** Auditor finalizes approval of *all* supplemental data for POs. Primary source verification (PSV) for nonstandard supplemental data must not occur prior to February 9, unless the PO finished all supplemental data processes, collection and entry. • **For Health Plans:** Auditor finalizes approval of *all* supplemental data for health plans. Primary source verification (PSV) for nonstandard supplemental data must not occur prior to March 1, unless the health plan finished all supplemental data processes, collection and entry.	March 8, 2024	March 29, 2024
Organization submits preliminary rates to the auditor for review. *Auditors should review preliminary rates based on the current year's specifications.*	March 29, 2024	
Supplemental Data to Health Plans: Health plans receive the audited supplemental data files and audit results from the PO.	March 29, 2024	
Data Layout Test Files: Self-reporting POs and health plans submit data layout test files to FinThrive HealthCare, Inc.	March 18–April 22, 2024	
Self-Reporting PO review period: Self-reporting POs review all submissions before sending to auditors to ensure data validity and completeness. ***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 FinThrive Healthcare, Inc.*	April 15–April 22, 2024	NA
Submission Files to Auditors: Self-reporting POs and health plans send submission files to auditors.	April 22, 2024	
Auditor-Locked Results: Self-reporting POs and health plans submit auditor-locked clinical results to FinThrive HealthCare, Inc. 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 3, 2024	
Resubmission of Auditor-Locked Results: Self-reporting POs and health plans submit auditor-locked clinical results to FinThrive HealthCare, Inc., if needed.	October 2024	

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 2023 Data Submission: Production file received by Onpoint: Monthly eligibility between January 1 and March 31, 2023, and all claims paid or changed through March 31, 2023, not previously submitted.	April 28, 2023	April 28, 2023	April 28, 2023		April 28, 2023	April 28, 2023
Q2 2023 Data Submission: Monthly eligibility and all claims paid or changed between April 1 and June 30, 2023.	July 28, 2023	July 28, 2023	July 28, 2023		July 28, 2023	July 28, 2023
Q3 2023 Data Submission: Monthly eligibility and all claims paid or changed between July 1 and September 30, 2023.	October 30, 2023	October 30, 2023	October 30, 2023		October 30, 2023	October 30, 2023
Q4 2023 Data Submission: Monthly eligibility and all claims paid or changed between October 1 and December 31, 2023.	January 30, 2024	January 30, 2024	January 30, 2024		January 30, 2024	January 30, 2024
Q1 2024 Data Submission: Production file received by Onpoint: Monthly eligibility between January 1 and March 31, 2024 and all claims paid or changed through March 31, 2024.	April 26, 2024	April 26, 2024	April 26, 2024		April 26, 2024	April 26, 2024
Annual File Submission: Production file received by Onpoint: Eligible members enrolled for at least one day between January 1 and December 31, 2023 who are also included in eligibility file submissions (no continuous enrollment criteria apply).				April 26, 2024		
Annual File Submission: Production file received by Onpoint: Cost results pertaining to services paid or changed between January 1 and March 31, 2023.					May 10, 2024	
MY 2023 Validation Report to Plan.*	TBD	TBD	TBD	TBD	TBD	
MY 2023 Plan Validation & Sign-Off.*	TBD	TBD	TBD	TBD	TBD	

****The deadline dates for the MY 2023 Validation Report will be finalized and shared with AMP participants in early 2024.***

AMP Report Release Dates and Review Period (Onpoint-generated and Quality results)

Activity or Milestone	Time Frame or Deadline
Preliminary AMP Onpoint-generated and Quality Reports Release for AMP Commercial HMO, Medicare Advantage, and Medi-Cal Managed Care : IHA posts preliminary Onpoint-generated and Quality 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. Quality reports include results from measures based on health plan and/or PO clinical submissions as specified in the AMP measure sets.	August 8, 2024
AMP 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. • **Quality Questions and Appeals Submission Deadline** • **Onpoint-generated Questions and Appeals Submission Deadline**	August 8–September 6, 2024 August 30, 2024 September 6, 2024
Resubmission of Auditor-Locked Results: Self-reporting POs and health plans submit auditor-locked clinical results to FinThrive HealthCare, Inc, if needed.	September 13, 2024
AMP Appeals Hearing: The Appeals Panel reviews and decides on all appeals to change Quality and Onpoint-generated results, if needed.	September 18, 2024
Resubmission of Onpoint Results: Health plans resubmit results to Onpoint Health Data, if needed.	September 19, 2024
Final Reports Released for AMP Commercial HMO, Medicare Advantage, and Medi-Cal Managed Care: 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. ***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.*	October 31, 2024

Review and Correction of MY 2023 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 17 business days to review preliminary Quality results, and 21 business days to review preliminary Onpoint-generated 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 Period. Detailed instructions on how to submit a question or request an appeal will be provided before the Questions and Appeals Period.

- **Preliminary Quality Reports** are released on **August 8, 2024**, and the final date to submit an appeal is **August 30, 2024**. 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 8, 2024**, and the final date to submit an appeal is **September 6, 2024**. 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 POs, 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 2023

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 FinThrive Healthcare, Inc. 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 FinThrive Healthcare, Inc. must be audited to ensure that results are an accurate reflection of PO performance. 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 2023 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.

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.

Patient Experience Domain

The survey used to collect data for the Patient Experience Domain is the national standard CAHPS®[4] 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; health plans do not submit data for this domain.

Refer to *Patient Experience 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). For the All-Cause Readmissions measure, IHA applies a minimum denominator threshold of 30 for public reporting. All other Appropriate Resource Use results are not publicly reported but may be used by health plans as the basis for performance incentives.

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

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.

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

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. The measures below have been selected for MY 2023 testing in the AMP program (barring issues that may impact the testing timeline). The Program Governance Committee confirmed adoption of these measures in Fall 2022 with input from Public Comment and recommendations from the Technical Measurement Committee.

All health plans and self-reporting POs are strongly encouraged to report testing measure results.

Organizations that intend to report the DSF-E testing measure should download the AMP Digital Measure Package from the NCQA Store.

Clinical Quality	• Prenatal and Postpartum Care (PPC) (testing in Commercial HMO only). • Depression Screening and Follow-Up for Adolescents and Adults (DSF-E). • Transitions of Care (TRC). • Well-Child Visits in the First 30 Months of Life (W30).
Data Quality	None.
Patient Experience	None.
Appropriate Resource Use	None.
Cost	None.

If You Have Questions About the AMP Programs

Policy Clarification Support

Participants who have questions regarding the AMP programs should submit them through My NCQA.

Step 1 Go to the My NCQA page.

Step 2 Complete the **Register** section.

Step 3 Log in and click **My Questions**.

- To ask a new question click **Ask a Question.**
- Click **PCS Policy/Program Clarification Support.**
- For *Product/Program Type,* click **IHA — AMP Programs** in the drop-down box.
- For *General Content Area,* select the appropriate category for your question.
- For *Specific Area,* scroll down and click the appropriate measure for your question, or click **Not Applicable** if your question type is not listed.
- For *Publication Year,* click **2023** for MY 2023 from the drop-down box.
- For *Subject*, enter a short subject for your question.
- Type your question (3,000 characters or less).

Step 4 Click **Submit Your Question**.

AMP Technical FAQs

The AMP Technical FAQs and Policy Updates clarify HEDIS and AMP uses and specifications, and are posted to the IHA website, as needed.