AMP Align. Measure. Perform. | Integrated Healthcare Association

Fact Sheet

Innovation through Collaboration

October 2018

AMP Commercial HMO

Using Standard Measurement & Alternative Payment Models to Promote Health Care Quality and Affordability

*IHA's **Align. Measure. Perform. (AMP)** programs use a fair and transparent approach to measurement and benchmarking to create a reliable assessment of performance for medical groups, IPAs, and ACOs across health plans. The AMP programs are recognized nationally for partnering with organizations across California and the nation to drive meaningful changes that reduce costs and improve healthcare quality and outcomes. Paired with the insights from IHA's California Regional Health Care Cost & Quality Atlas, the AMP programs help partners reduce the reporting burden for payers and providers by using a standard measure set to deliver objective data and analysis that supports performance improvement.*

About

The AMP Commercial HMO program (formerly known as Value Based Pay for Performance [VBP4P]) is the cornerstone upon which all of IHA's performance measurement programs were built. Initiated in 2001, the program now includes participation from nine health plans and nearly 200 California physician organizations caring for over 9 million Californians enrolled in commercial HMO and point of service products - representing 95% of commercial HMO enrollment in the state. AMP Commercial HMO has four key components: a common set of measures and benchmarks that span clinical quality, patient experience, utilization, and cost of care measures; value-based health plan incentive payments; public reporting of Triple Aim performance results; and public recognition awards. AMP Commercial HMO has demonstrated lasting and meaningful gains in quality performance, suggesting that a common performance signal supports targeted improvement efforts.

Measure Set

The adoption of a common set of performance measures and benchmarks by participating health plans and physician organizations helps harness collective market forces to drive improvement in patient care. Aggregating performance data across participating health plans at the physician organization level significantly improves measurement reliability and validity, which decreases reporting burden for physician organizations by eliminating competing and conflicting health plan rating systems. The AMP Commercial HMO common measure set relies on evidence-based measures in four areas:

- **Clinical Quality:** Quality measurement includes process, intermediate outcome, and outcome measures, using standardized national measure specifications in six clinical priority areas: prevention, cardiovascular care, diabetes care, musculoskeletal conditions, respiratory conditions, and behavioral health & substance use.
- **Patient Experience:** AMP Commercial HMO incorporates patient experience measurement from the Patient Assessment Survey (PAS), which is based on the national Clinician & Group CAHPS survey tool and is fielded by the Pacific Business Group on Health (PBGH). The PAS asks patients to rate care received from their doctor and other providers in the physician organization. Ratings assess areas such as communication with their doctor, timely access to care, coordination of care, and overall ratings of care.
- **Advancing Care Information (ACI):** The ACI domain includes two electronic clinical quality measures (e-measures) and aims to align with federal efforts to promote health IT adoption and use. The measures reflect a physician organization's ability to collect and report on EHR-derived performance measures across its primary care physicians.
- **Resource Use and Total Cost of Care:** Appropriate resource use measures are based on inpatient readmissions, inpatient and outpatient utilization, emergency department visits, and generic prescribing. Since 2011, a measure of total cost of care, based on actual health plan payments for each enrollee's care including professional, pharmacy, hospital, and ancillary services and consumer cost-sharing, has been calculated and risk adjusted for each physician organization.

Health Plan Incentive Payments

Working with health plan and physician organization representatives, IHA developed a recommended value-based incentive design for use by health plans participating in AMP Commercial HMO. Each health plan is free to adapt the design and is solely responsible for making incentive payments to

contracted physician organizations. The incentive design incorporates all measurement areas: clinical quality, patient experience, advancing care information, resource use, and total cost of care.

The incentive design is at its core a shared savings design. It is upside only, and physician organizations bear no downside financial risk. To be eligible to earn any share of savings, physician organizations must meet minimum quality and total cost of care standards; those that do not meet these standards are not eligible for incentives. Savings are earned by improvement in resource use measures, and any savings generated are divided between the health plan and the physician organization. The recommended share of savings to the physician organization increases or decreases based on overall quality performance, reinforcing the importance of quality in the design. To ensure that physician organizations who consistently maintain highly efficient resource use are appropriately rewarded, a complementary attainment incentive is part of the design.

Public Reporting

IHA partners with the California Office of the Patient Advocate (OPA) to publicly report the AMP Commercial HMO results annually, enabling consumers to compare performance of physician organizations within a county, including overall performance, clinical topic areas, and individual rates for quality, patient experience, and total cost of care measures.

Public Recognition Awards

IHA recognizes top-performing physician organizations as well as those demonstrating the greatest year-to-year improvement regionally with the following public recognition awards:

- The Excellence in Healthcare Award recognizes physician organizations that achieve top marks on quality and patient experience measures while effectively managing costs. To earn this recognition, physician organizations must demonstrate value by performing in the top 50 percent in clinical quality **and p**atient experience **and** total cost of care.
  - Recognizing the importance of quality, patient satisfaction, and cost moderation in providing high-value care, IHA recognizes physician organizations that perform in the top ten percent of participating physician organizations in one or more domains: clinical quality, patient experience, or total cost of care.
- In memory of his contributions and dedication to quality improvement, the Ronald P. Bangasser, M.D., Memorial Award for Quality Improvement recognizes the physician organization in each of eight California regions that demonstrated the greatest relative year-over-year improvement in quality performance.

About IHA

Founded in 1994 and based in Oakland, CA, the nonprofit, nonpartisan Integrated Healthcare Association is guided by a 40-member board of industry-leading health plans, physician organizations, and hospitals and health systems, plus representatives of purchaser, consumer, academic, pharmaceutical, and technology entities. As a member-driven organization convening diverse stakeholders committed to advancing high-quality, affordable, patient-centered care, IHA generates objective data and insights to help forge common ground across California's health care community. For more information, visit www.iha.org.

Lindsay Erickson, MSPH, Director
lerickson@iha.org

500 12th Street, Suite 310 • Oakland, Calif. 94607
(510) 208-1740 • www.iha.org