Integrated Healthcare Association

Align. Measure. Perform. (AMP) Programs Value-Based Incentive Design

Measurement Year 2021

Updated October 2022

www.iha.org

Table of Contents

Executive Summary

This document outlines in detail the standard IHA value-based incentive design for the AMP Commercial HMO and Medi-Cal Managed Care programs. Nearly all participating health plans use AMP results to pay incentives to provider organizations. To date, nine health plans—Aetna, Anthem Blue Cross, Blue Shield of California, Blue Shield of California Promise Health Plan, Cigna, Health Net, Sharp Health Plan, UnitedHealthcare, and Western Health Advantage—have committed to transitioning to IHA's value-based incentive design methodology.

About the AMP Programs

In a fee-for-service environment, payments to providers and provider organizations (POs) are driven by the volume of healthcare services rendered, regardless of the quality of care provided to patients. To change this equation, the Integrated Healthcare Association (IHA) partnered with California-based health plans and POs to launch a statewide pay-for-performance initiative (P4P) in 2003. This initiative aimed to create compelling incentives to drive improvements in clinical quality and patient experience performance. The program's core components included: (1) a common set of measures, (2) a performance-driven incentive payment model that health plans can use to reward POs, (3) a public report card, and (4) PO recognition awards.

While steady improvements in clinical quality and patient experience performance were achieved, the dramatic increases in healthcare costs over the decade overshadowed these gains. In 2010, IHA stakeholders called for a modification of the existing program to reward performance on quality, cost, and resource use measures in an integrated fashion. As a result, the pay-for-performance initiative evolved into the Align. Measure. Perform. (AMP) program, which today includes 14 health plans and over 200 POs caring for more than 13 million Californians spanning across Commercial HMO/POS, Medicare Advantage, and Medi-Cal Managed Care. The four program components continue in operation under a value-based healthcare framework.

About the IHA Value-Based Incentive Design

IHA's value-based incentive design, which combines clinical quality, patient experience, Advancing Care Information (ACI), Total Cost of Care (TCOC), and Appropriate Resource Use (ARU) measures, is one of the largest alternative payment models in the country. At its core, the program is based on ARU improvement (shared savings) and attainment, adjusted for performance on a "quality" composite of clinical quality, patient experience, and ACI measures. The incentive design aims to improve quality, decrease costs, and reward providers for delivering high-value care.

The design is upside risk only; participants can earn incentives through improvement or attainment but bear no downside financial risk. To be eligible for incentives, POs must first meet minimum quality and cost standards, known as the Quality Gate and TCOC Gates. POs that do not meet all required gates are ineligible for incentives.

Savings are earned through improved resource use, based on five common measures: inpatient discharges, readmissions, emergency department (ED) visits, outpatient procedures, and generic prescribing. After summing incentive amounts across all measures and adjusting for a PO's quality performance, any savings earned are shared

between the health plan and the PO. To maximize the share of savings earned, a PO must achieve greater improvements in ARU performance while simultaneously offering higher quality care.

Improving ARU performance year-to-year is challenging, particularly for POs that already demonstrate efficient resource use. To ensure that POs with efficient resource use are appropriately rewarded, a complementary attainment incentive was added to the design in 2015. This methodology builds in a supplement to the shared savings calculation for POs that consistently exceed population benchmarks for ARU measures.

More information can be found at iha.org, and questions can be sent to amp@iha.org.

Overview

Since the inception of the California P4P program in 2003, IHA has created a successful statewide performance measurement collaboration that includes uniform measures, aggregated data collection and validation, and a trusted governance process. The AMP programs emerged from the California P4P initiative to help moderate the commercial HMO cost trend in California while continuing to improve the quality of care. A key component of the initiative involved transitioning health plan financial incentives to POs from focusing solely on rewarding quality to rewarding value by adding costs and appropriate resource use as performance components.

The IHA value-based incentive design is a shared savings and attainment model that incorporates the quality, cost, and appropriate use of health care services. The value-based incentive design was developed in collaboration with participating AMP health plans and POs and was approved in 2012. Starting in Measurement Year (MY) 2013, health plans began to phase out the former quality-only P4P incentive program and implement the IHA value-based incentive design. As plans implemented the new design, refinements were made and adopted by the three IHA committees—Program Governance, Technical Measurement, and Technical Payment. Historical design changes are logged for reference in Appendix F.

Incentive Design Objectives

The purpose of the IHA value-based incentive design is to revitalize the AMP programs against a backdrop of affordability. The objectives of the incentive design are as follows:

- Prioritize cost control.
- Promote quality.
- Standardize health plan utilization measures and payment methodology.
- Increase funding to the incentive program using a shared savings and attainment model.

Incentive Design Guiding Principles

1. Savings generated by the IHA value-based incentive design are intended to contribute to lower cost trends and a more competitive, value-based HMO product.
2. The IHA value-based incentive design is intended to be available to all POs—including full-risk POs—that contract for commercial HMO or POS business with one or more participating health plans.
3. POs that contribute to HMO price competitiveness through efficiencies and quality should be rewarded for their efforts to provide value.
4. The IHA value-based incentive design should not increase a health plan's total cost trend. The shared savings design must balance appropriate PO rewards for successfully achieving quality and cost targets with budgeting for potential overruns by other POs.

Incentive Design Elements

There are five core elements of the incentive design: **(1) a common measure set, (2) performance gates, (3) incentives based on ARU measures, (4) quality adjustments, and (5) the summation of incentive amounts across measures**. IHA value-based incentive payments can be earned in two ways: through ***improvement* (*shared savings) incentives*** that reward year-over-year improvement and ***attainment incentives*** that reward continued excellence in resource stewardship. A PO may be eligible for incentives through both pathways based on their performance.

The incentive design relies on a **common measure set**. To be eligible to earn any share of savings, POs must first meet quality standards, as well as demonstrate a TCOC trend and amount below established thresholds. These standards are referred to as the **performance gates**, specifically the Quality Gate, TCOC Trend Gate, and TCOC Amount Gate.

Shared savings are generated by PO improvements in **resource use**, based on five common measures: inpatient discharges, readmissions, ED visits, outpatient procedures, and generic prescribing. Any **savings** generated are shared between the health plan and the PO. Additionally, to reward POs that consistently demonstrate excellent performance on resource use, an attainment incentive supplements the estimated shared savings. Under the attainment pathway, a PO's performance on each ARU measure is compared to population benchmarks, and POs achieving and maintaining these high-performance levels are eligible for the supplemental attainment incentive.

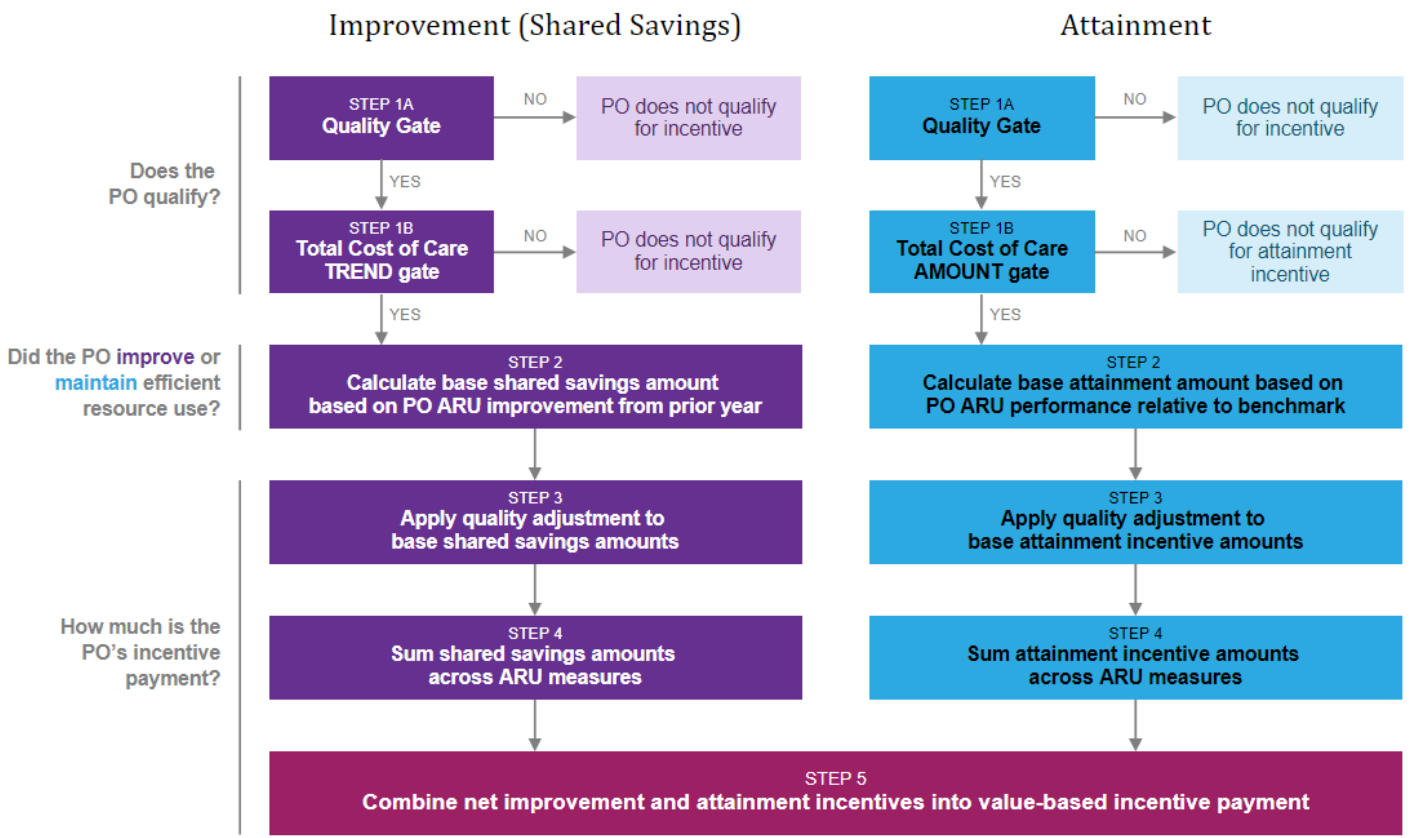
Applied to both the shared savings and attainment incentives, a **quality adjustment** increases or decreases the amounts to reflect a PO's quality performance. Finally, ***shared savings*** and ***attainment incentives*** are summed across all five ARU measures. Each measure's shared savings can be positive or negative, and positives—generated either through improvement and/or attainment—can offset any negatives. To maximize an incentive award, a PO must demonstrate resource use improvement and/or excellent resource use stewardship while simultaneously offering higher quality care.

To balance the need for standardization and adaptability, the IHA committees characterize design elements as core and optional. The core elements are considered essential to the IHA value-based incentive design, while optional design elements offer health plans flexibility to fine-tune the methodology to accommodate their business practices and strategies.

Core Design Elements	Optional Design Elements

• Common Measure Set
• Performance Gates
  ○ Quality Gate
  ○ TCOC Trend Gate
  ○ TCOC Amount Gate
• ARU Improvement (Shared Savings) Incentive
• ARU Attainment Incentive
• Quality Adjustment
	• Threshold/Gate Values
	• Multiplier Ranges/Values
	
	★ *Throughout the document, IHA committee recommendations on optional design elements are signified with a star; a summary of all recommendations on optional values is included in Appendix A.*

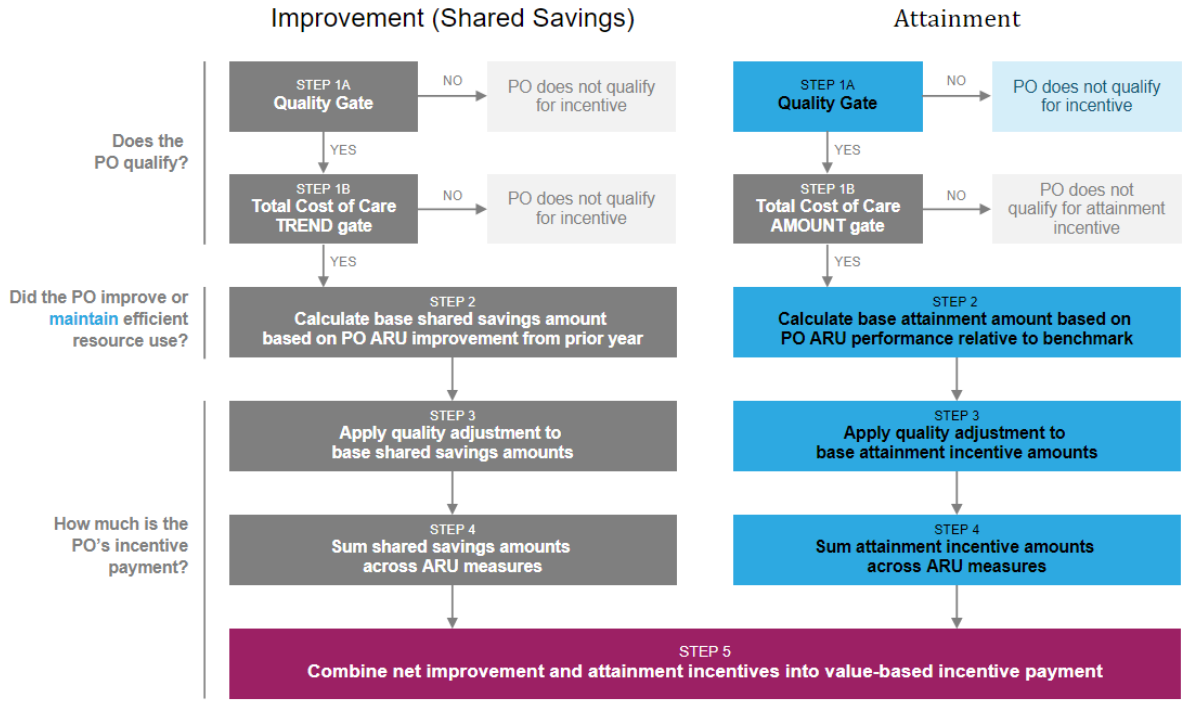
IHA Value-Based Incentive Design Diagram



MY 2021 Incentive Design Recommendations

IHA Committee Recommendation	Rationale
Apply the Quality Gate only when assessing PO incentive eligibility; waive the TCOC Amount Gate and TCOC Trend Gate.	• The magnitude of the COVID-19 pandemic's impact on MY 2021 results is not clear and difficult to isolate from other factors, even for areas that POs have some control over. • The recommended approach mitigates the risk of unfairly penalizing POs for cost performance, which may have been impacted by the COVID-19 pandemic. • Applying the Quality Gate only when assessing PO incentive eligibility is consistent with the MY 2020 incentive design approach, which was developed to address potential COVID-19 impacts.
For the clinical quality and patient experience domains, set the attainment threshold at the baseline year 50th percentile; maintain the attainment benchmark (set at the baseline year 95th percentile) and improvement scoring methodology as-is. This update applies to MY 2021 and future measurement years.	• Evidence suggests that the attainment threshold update would most benefit the POs performing above the median but below the 75th percentile. • An attainment threshold of the 50th percentile aligns with broader industry approaches (e.g., CMS Hospital Value-Based Purchasing program).
Waive the improvement pathway and fully utilize the attainment pathway as the basis of PO incentive payments.	• It may not be appropriate nor meaningful to incorporate ARU trending for MY 2021, given COVID-19's impacts on utilization.
Expand the attainment targets to include the 50th percentile in addition to the 75th and 90th percentiles, with higher targets earning larger incentives.	• Assuming the removal of the improvement pathway, expanding the attainment targets ensures POs continue to have opportunities to earn incentives via the attainment pathway.
Utilize MY 2020 as the baseline measurement year in MY 2021 incentive design.	• From the AMP participant perspective, it is less confusing and therefore more preferrable to use the same baseline measurement year across all elements of the incentive design – Quality Composite Score methodology, attainment pathway of the shared risk design, and, if applicable, TCOC Amount Gate. • Based on preliminary ARU mean results, MY 2021 performance is more comparable to MY 2020's; differences between baseline and measurement year ARU results may be less gradual if using MY 2019 as the baseline. • Modeling shows that for most resource use measures, there is not a substantive difference in the proportion of POs meeting each attainment target when using MY 2020 vs. MY 2019 as baseline year.

IHA Value-Based Incentive Design Diagram – MY 2021



Use of the current **Attainment Incentive pathway** with updated performance targets

TCOC Trend and Amount Gates **waived** for MY 2020

Updated performance targets per utilization measure ($ PMPY)

90th
75th
Existing Targets

50th
Expanded Target

Greyed-out areas have been removed from MY 2021 incentive design methodology to adjust for COVID-19 pandemic impacts. These modifications represent a one-time adjustment for MY 2021.

Calculating Value-Based Incentive Payments

The core design elements—a common measure set, performance gates, improvement (shared savings) and attainment incentives based on resource use, quality adjustments, and the summation of incentive amounts—can be tracked across the parallel and complementary improvement and attainment incentives, which ultimately converge to produce the total incentive amount earned by a PO.

The improvement incentive assesses a PO's performance relative to its baseline year performance. The attainment incentive assesses a PO's performance relative to population benchmarks and is designed to reward high-performing POs that meet and maintain excellent resource use standards. Both the improvement and attainment incentives are combined; POs that both improve and meet attainment benchmarks are eligible to earn both incentives. The design, including improvement and attainment, is outlined in detail below.

For MY 2021, the IHA committees have recommended several updates to the value-based incentive design to account for COVID-19 pandemic impacts. Updates are indicated in red italicized font.

Common Measure Set

The incentives are based on a common measure set established for the program. The measure set is updated annually and evolves as advancements in health care performance measurement occur. For the incentive design, the measures can be categorized as follows:

- **Quality** measures encompass clinical quality, patient experience, and ACI (e-measures). A composite score of these measures is used as a performance gate and as an adjustment that increases or decreases a PO's incentives.
- **ARU** measures capture key aspects of utilization—inpatient discharges, readmissions, ED visits, outpatient services, and generic prescribing—that contribute to the overall costs of care and are influenced by PO coordination and management of patient care. Improvement and attainment on these measures drive the incentive amounts.
- A **TCOC** measure comprised of actual payments associated with care for all enrollees in a PO for the measured population (e.g., Commercial HMO/POS, Medi-Cal Managed Care). The TCOC trend (i.e., percent change between years) and TCOC amount are used as performance gates.

Step 1: Apply Performance Gates

Both improvement (shared savings) and attainment incentives require POs to meet performance gate thresholds. These performance gates ensure that POs meet specified quality and cost performance criteria to be eligible for any incentive. The first eligibility gate, the **Quality Gate**, is applied for both improvement (shared savings) and attainment. The second eligibility gate, the **TCOC Gate**, is specifically tailored to the improvement (shared savings)

and attainment incentives. For the improvement (shared savings) pathway, the cost gate assesses **TCOC Trend**. For attainment, the cost gate assesses relative **TCOC Amount**.

To be eligible for improvement (shared savings) incentives, POs must meet both the Quality Gate and TCOC Trend Gate. To be eligible for attainment incentives, POs must meet both the Quality Gate and TCOC Amount Gate.

★ ***IHA Committee Recommendation (MY 2021 only):*** *IHA committees recommend waiving both the TCOC Trend Gate and TCOC Amount Gate and applying the Quality Gate only when assessing PO incentive eligibility. The rationale underlying this decision is as follows:*

- *The magnitude of the COVID-19 pandemic's impact on MY 2021 results is not clear and difficult to isolate from other factors, even for areas that POs have some control over.*
- *The recommended approach mitigates the risk of unfairly penalizing POs for cost performance, which may have been impacted by the COVID-19 pandemic.*
- *Applying the Quality Gate only when assessing PO incentive eligibility is consistent with the MY 2020 incentive design approach, which was developed to address potential COVID-19 impacts.*

Quality Gate

This performance gate establishes a minimum level of quality performance that a PO must demonstrate to be eligible for any incentives.

A Quality Composite Score (QCS) for each PO is calculated by IHA based on performance across the clinical quality, patient experience, and ACI (e-measure) domains. A detailed description of the QCS methodology can be found in Appendix B. Of note, the methodology:

- Includes all measures in these domains that are recommended for payment. For the complete list of measures recommended for payment, please refer to the measure set for the appropriate measurement year.
- Uses the better of aggregated or self-reported results that reflect performance across all contracted health plans.
- Scores measure performance for both attainment and improvement.
- A PO's QCS must meet or exceed the Quality Gate threshold to earn incentives from health plans.

Quality Composite Score (QCS) Example

AMP Quality Domain	AMP Domain Score	AMP Domain Weighting	Weighted Domain Score
Clinical	40	60%	24
Patient Experience	29	30%	8.7
Advancing Care Information (ACI)	67	10%	6.7
Quality Composite Score			**39**

★ **IHA Committee Recommendation:** The recommended Quality Gate threshold is set at the current year 10th percentile for the QCS, which sets a bar for quality that is attainable for POs while still ensuring a baseline expectation for performance.

Total Cost of Care Gates – *Waived for MY 2021*

The cost performance gates establish ceilings that POs cannot exceed to be eligible for incentives. The gates serve to reinforce and ensure that the calculated incentives based on ARU are not directly at odds with corresponding performance on cost.

- The improvement (shared savings) incentive rewards improvement in resource use, so the complementary cost performance gate assesses Total Cost of Care *Trend.*
- The attainment incentive rewards relative performance in resource use, so the complementary cost performance gate assesses Total Cost of Care *Amount.*

TCOC Trend Gate (for the Improvement [Shared Savings] Pathway only) – Waived for MY 2021

This performance gate establishes a maximum TCOC Trend that a health plan-PO contract cannot exceed to be eligible for an improvement (shared savings) incentive.

- The TCOC Trend is the percent change between a PO's current and baseline measurement year TCOC and is specific to each health plan.
- A one-sided 85% lower confidence interval around the estimated TCOC trend is calculated to help ensure that POs with small plan membership are not excluded from participation due to less stable TCOC results.
- To be eligible for improvement (shared savings) incentives, a health plan-PO contract's TCOC trend, including a confidence interval, must be below the TCOC Trend Gate threshold. The recommended threshold is tied to the Consumer Price Index (CPI) and described in more detail later.

★ **IHA Committee Recommendation:** The recommended TCOC Trend Gate threshold is based on and set slightly above the CPI. In alignment with the original program goal of reducing costs, the recommended TCOC Trend Gate threshold will start at CPI+3 percentage points and gradually decrease over time, as outlined below.

Consistently high-cost POs represent the greatest savings opportunity. To abide by the guiding principle that all POs should be able to participate, these POs are eligible for incentives but may be subject to a more challenging TCOC Trend Gate.

Year	Standard	High-Cost PO
MY 2021	CPI+1%	CPI-1%

★ **IHA Committee Recommendation:** Consistently high-cost POs are defined as those POs that have geography- and risk-adjusted TCOC results ($250,000 truncation per member applied) at or above the 90th percentile both the baseline and measurement years. The TCOC result that is used is specific to each health plan-PO contract.

TCOC Amount Gate (for the Attainment Incentive Pathway only) – Waived for MY 2021

This performance gate establishes a maximum TCOC amount that a health plan-PO contract may not exceed to be eligible for attainment incentive.

- To be eligible for attainment incentives, a PO's TCOC amount cannot exceed the gate threshold value. POs with TCOC amounts above the gate are ineligible for attainment incentives.
- The TCOC amount is the PO's geography- and risk-adjusted TCOC result for a respective health plan.

★ **IHA Committee Recommendation:** The recommended TCOC Amount Gate threshold is the same as consistently high-cost PO definition—the 90th percentile geography- and risk-adjusted TCOC ($250,000 truncation per member applied) for a contracted health plan for both the baseline and measurement year.

Step 2: Calculate Base Incentive Amounts

Step 2 begins the calculation of incentive amounts for eligible POs. The base improvement (shared savings) pathway estimates the value of improvement on the ARU measures, while the base attainment incentive estimates a bonus representing the ongoing value to the health plan of maintaining excellent performance on the ARU measures. In other words, POs generate incentives through resource stewardship that results in savings for the health plan. Those savings then serve as the basis for the combined net improvement (shared savings) and attainment incentives.

The following general principles apply to both the shared savings and attainment base incentive calculations:

- ARU measure performance is based on the PO's results specific to each contracted plan—this ensures health plan payments track to their own utilization experience with a PO.
- Incentives are calculated for each ARU measure:
    - Inpatient discharges (AHU)
    - All-cause readmissions (PCR)
    - ED visits (EDU)
    - Outpatient procedures—preferred facility use (OSU) *(Note: Although not recommended for use in the MY 2020 incentive design, this measure is recommended for use in MY 2021 incentive design.)*
    - Generic prescribing – overall (GRX)

Improvement (Shared Savings) Pathway – *Waived for MY 2021*

The improvement (shared savings) pathway calculation compares a PO's current and baseline year ARU performance and quantifies any improvement (or declines). The calculation then translates the measured improvement (or decline) into an estimate of savings (or added costs). To get to dollars, the improvement in the rate must be: (1) scaled to reflect the size of the PO's membership, (2) priced to incorporate the estimated costs for each ARU measure, and (3) split to reflect the initial share of savings between the health plan and PO.

- A PO's utilization target for each ARU measure is generally its own baseline year performance. (See Methodological Considerations for guidance on how to handle ARU rates for small POs.)
- The total estimated savings amount is calculated using the units of improvement or decline achieved by the PO for a particular resource use measure.
- Units of improvement are translated to an estimate of savings by pricing the units according to their respective costs. For example, if a PO avoided or reduced 100 ED visits and the cost per ED visits is $750, the total estimated savings are $75,000.
- Estimated savings can be positive or negative. All amounts are carried through to the final calculation.
    - Savings are positive if the PO's measure performance improved compared to the previous year.
    - Savings are negative, reflecting added costs, if the PO's measure performance declined compared to the previous year.

★ **IHA Committee Recommendation:** The base incentive amount for the PO starts at 50% of the shared savings amount.

★ **IHA Committee Recommendation:** A PO's target is its own baseline (i.e., prior) year performance for the same measure.

Attainment Pathway

The attainment pathway increases the payment opportunity for POs that demonstrate excellent resource stewardship over time. POs that exceed the attainment benchmarks for an ARU measure for the current and baseline measurement year—demonstrating they have achieved and maintained efficient resource use—earn a supplement that is incorporated into their final incentive.

- For each ARU measure, a PO's performance for the current year and baseline measurement year are compared to the respective attainment benchmarks (see recommendation below).
- For any ARU measure where the PO meets or exceeds the respective benchmarks for **both** measurement years, the PO earns the corresponding attainment incentive amount.
- If the PO does not meet the identified benchmark criteria for an ARU measure for either the current or baseline measurement year, the PO does not earn the attainment incentive for that measure.

★ **IHA Committee Recommendation:** The recommended attainment benchmarks reflect a two-tier set of targets set at the 75th and 90th percentiles of performance for all POs in the population (i.e., AMP Commercial HMO benchmarks). The higher benchmark earns a larger incentive.

For MY 2021 only, the IHA committees recommend waiving the improvement pathway and fully utilizing the attainment pathway as the basis of PO incentive payments. Furthermore, the IHA committees recommend expanding the attainment targets to include the 50th percentile in addition to the 75th and 90th percentiles, with higher targets earning larger incentives. The rationale underlying this decision is as follows:

- *It may not be appropriate nor meaningful to incorporate ARU trending for MY 2021, given COVID-19's impact on utilization.*
- *Assuming the removal of the improvement pathway, expanding the attainment targets ensures POs continue to have opportunities to earn incentives via the attainment pathway.*

Step 3: Apply Quality Adjustment to Base Incentive Amount

In addition to determining PO eligibility for incentives (see Step 1: Apply Performance Gates), quality performance is used to adjust the incentive amount earned by POs. POs with higher quality will see their earned incentive amount increase, while POs with lower quality will see their earned incentive amount decrease.

Quality Adjustment

The quality adjustment translates a PO's quality performance into an upward or downward adjustment (i.e., multiplier) that is applied to both the improvement (shared savings) and attainment incentives.

- A PO's QCS (same as described in Step 1: Apply Performance Gates) is used to determine its Quality Multiplier.
- The Quality Multiplier is calculated based on a continuous linear scale that is capped with a floor (minimum) and a ceiling (maximum). Below the floor (i.e., the Quality Gate), POs do not earn any incentives; above the ceiling, POs continue to earn the maximum Quality Multiplier. Between the floor and ceiling, increases in the QCS result in a higher multiplier and therefore greater incentive amount.
- The Quality Multiplier is applied to the base improvement (shared savings) and attainment incentives for each ARU measure.

★ **IHA Committee Recommendation:** The IHA committees recommend setting the Quality Multiplier floor at 0.65 and the ceiling at 1.35. This translates to a 35% decrease or increase in a PO's incentive, respectively. A PO with a QCS at the current measurement year's 10th percentile would earn the minimum Quality Multiplier, while a PO with a QCS at the current measurement year's 90th percentile would earn the maximum Quality Multiplier.

Step 4: Sum the Incentive Amounts Across ARU Measures

The final step is to sum the quality-adjusted incentive amounts across ARU measures. Summing the incentives across measures establishes a broad level of accountability by requiring that POs offset any losses from ARU declines to earn an incentive.

Improvement (Shared Savings) Pathway – *Removed for MY 2021*

The quality-adjusted shared savings (see Step 3: Apply Quality Adjustment to Base Incentive Amount) will be positive if performance on the ARU measure improved or negative if performance on the ARU measure declined. Summing the estimated savings or losses for each ARU measure generates an estimate of net shared savings that can be positive (reflecting net savings) or negative (reflecting net added costs). To earn net positive shared savings, a PO's savings from improvements for some ARU measures must offset any declines in a PO's performance on the remaining ARU measures.

Attainment Pathway

The quality-adjusted attainment incentives (see Step 3: Apply Quality Adjustment to Base Incentive Amount) will be positive for any ARU measure where the PO has achieved and maintained strong performance. For any measures where a PO has not met and maintained the benchmark performance, the incentive is simply $0. Summing the attainment incentives across measures yields a total attainment incentive amount.

Step 5: Calculating Total Incentives

Health plans combine a PO's net improvement (shared savings) (positive, 0, or negative) and net attainment incentives (0 or positive) to determine the final incentive payment amount. *For MY 2021, the total PO incentive payment amount will be based on the attainment pathway for the ARU measures recommended for payment.*

- If the combined incentive is positive, the PO earns that amount as an incentive.
- If the combined incentive is negative, the PO earns $0 and does not bear the estimated loss.

Methodological Considerations

Small POs

Guidance for Incentive Design Implementation for Small POs

The reliability and year-over-year stability of measure results may be problematic for some POs, especially small POs. Therefore, the IHA committees recommended providing options to health plans paying on IHA results for small POs. Health plans can offer incentives to small POs using either the:

- PO all-plan aggregated results, or
- Small PO pooled results, which are generated by IHA and provided to the health plans

Small Provider Organization PO Pooling Methodology

For the small PO pooling methodology, the IHA committees recommended calculating a weighted small PO result for the ARU measures on a plan-specific basis and using this value as the basis for shared savings calculations. This weighted small PO result will be provided to small POs in addition to the PO's own measure result.

- Small POs are defined as those with fewer than 5,000 member years of commercial HMO/POS enrollment with a health plan.
- To calculate the weighted small PO result, the results for all small POs within each plan are pooled.
- A weighted average, based on enrollment, is used to blend the pooled result with each small PO's own measure result.
- The weighting placed on the PO's own result increases proportionally with membership from 0 member years up to 5,000 member years.

Full-Risk POs

Overview

One of the guiding principles of the AMP value-based incentive design is that the program is intended to be available to all POs, including full-risk POs. In the incentive design for shared risk POs, the amount of shared savings is calculated based on reductions in unnecessary resource use (e.g., inpatient discharges and ED visits) and adjusted by quality performance. However, full-risk POs receive a member-level capitated payment that covers hospital service utilization. As a result, reductions in resource use in full-risk POs do not yield any health plan savings that can be shared. As such, a special incentive design is needed for full-risk POs.

Design Summary

1. **Apply Performance Gates**: Determine if the PO passes both the Quality Gate and TCOC Trend Gate. If so, the PO is eligible for an incentive.
2. **Calculate Quality Composite Score (QCS)**: See Appendix B.
3. **Generate Value Score:** Apply TCOC adjustment to QCS to adjust the QSC up or down based on a PO's relative TCOC amount performance. The PO's TCOC performance compares a PO's geography- and risk-adjusted TCOC amount ($250,000 truncation per member applied) against PO performance for the AMP population being measured (e.g., AMP Commercial HMO, AMP Medi-Cal Managed Care).
4. **Determine Incentive Payment:** Value scores and membership information for POs are used by health plans to distribute incentives across their full-risk POs.

For an example of the calculation, see Appendix C.

★ **IHA Committee Recommendation:** The cost performance adjustment varies based on a continuous linear scale from a decrease of 20% to an increase of 20% based on the PO's geography- and risk-adjusted TCOC for the measurement year and specific plan. The maximum and minimum adjustments correspond with the 10th and 90th percentiles of AMP PO performance on TCOC (including geography and risk adjustment).

★ ***IHA Committee Recommendation (MY 2021 only):*** *IHA committees recommend waiving both the TCOC Trend Gate and TCOC Amount Gate and applying the Quality Gate only when assessing PO incentive eligibility. The rationale underlying this decision is as follows:*

- *The magnitude of the COVID-19 pandemic's impact on MY 2021 results is not clear and difficult to isolate from other factors, even for areas that POs have some control over.*

- *The recommended approach mitigates the risk of unfairly penalizing POs for cost performance, which may have been impacted by the COVID-19 pandemic.*
- *Applying the Quality Gate only when assessing PO incentive eligibility is consistent with the MY 2020 incentive design approach, which was developed to address potential COVID-19 impacts.*

APPENDIX A: AMP Value-Based Incentive Design Recommended Values

To help channel variability and serve as a basis for comparing the implementation of the standard AMP incentive design across health plans, the IHA committees have identified recommended values for the incentive methodology.

Design Element	Recommended Value	Notes/Rationale
Quality Gate	Quality Composite Score (QCS) at or above the current year **10th percentile**	The recommended Quality Gate threshold is set at a QCS at the current year 10th percentile, which sets a bar for quality that is attainable for POs while still ensuring a baseline level of performance.
TCOC Trend Confidence Level	**85%**	Using a one-sided 85% confidence level increases the certainty that a PO is correctly excluded from incentive eligibility at the TCOC Trend Gate.
TCOC Trend Gate *Waived for MY 2021*	Standard Threshold Baseline measurement year -current measurement year: **CPI+1%** High-Cost POs Threshold Baseline measurement year -current measurement year: **CPI-1%**	The recommendation is to use a three-year average of the U.S. Consumer Price Index (CPI), which would be based on the measurement year and the two years immediately preceding the measurement year.
TCOC Amount Gate *Waived for MY 2021*	POs with geography- and risk-adjusted TCOC above the health plan-specific **90th percentile** for both the baseline and measurement year	To reward POs that consistently demonstrate excellent performance on resource use, an attainment incentive supplements the estimated shared savings. The recommended TCOC Amount Gate threshold is the same as consistently high-cost PO definition—the 90th percentile geography- and risk-adjusted TCOC for a contracted health plan for both the baseline and measurement year.
High-Cost PO Definition	POs with geography- and risk-adjusted TCOC above the health plan-specific **90th percentile** for both the baseline and measurement year	The committees believed it was important to hold POs that have consistently high costs to a stricter TCOC Trend Gate to further incentivize improved affordability.
Quality Adjustment	Continuous linear scale based on QCS values at the current year 10th percentile to the gold standard at the 90th percentile, corresponding to Quality Multipliers of **0.65** to **1.35**	This provides about a two-fold difference between the lowest qualifying performers and the highest performers and reinforces the importance of quality in the IHA incentive design. Considering the quality adjustment in isolation, multipliers of 0.65 and 1.35 correspond with a PO earning a 32.5% and 67.5% share of the savings, respectively.

APPENDIX B: Standard Payment Methodology (Quality Composite Score Calculation)

Background

The AMP value-based incentive design use a standardized methodology, based on the Centers for Medicare and Medicaid Services (CMS) Hospital Value-Based Purchasing model, to score each quality measure on both attainment and improvement. Attainment and improvement points are calculated first at the domain level (clinical quality, patient experience, and ACI). The higher point value (attainment or improvement) is used in downstream calculations and then combined into an overall summary of a PO's performance – the Quality Composite Score (QCS). In AMP, the QCS is used to determine incentive eligibility and adjust the share of savings a PO earns.

Methodology

Translating Clinical Quality and Patient Experience Performance into Points

1. **Attainment threshold:** AMP 50th percentile (including Kaiser Permanente) for the baseline (i.e., prior) year. The attainment threshold is the score needed to earn attainment points for a measure. Setting the threshold at the baseline year's 50th percentile means that only POs performing within top two quartiles based on the previous year's 50th percentile threshold would earn points for attainment. POs performing within the bottom two quartiles based on the previous year's 50th percentile threshold may be eligible for improvement points if their current measurement year results reflect improvements from the baseline year. Please note that the using the previous year's percentiles allows groups to know the targets ahead of time.

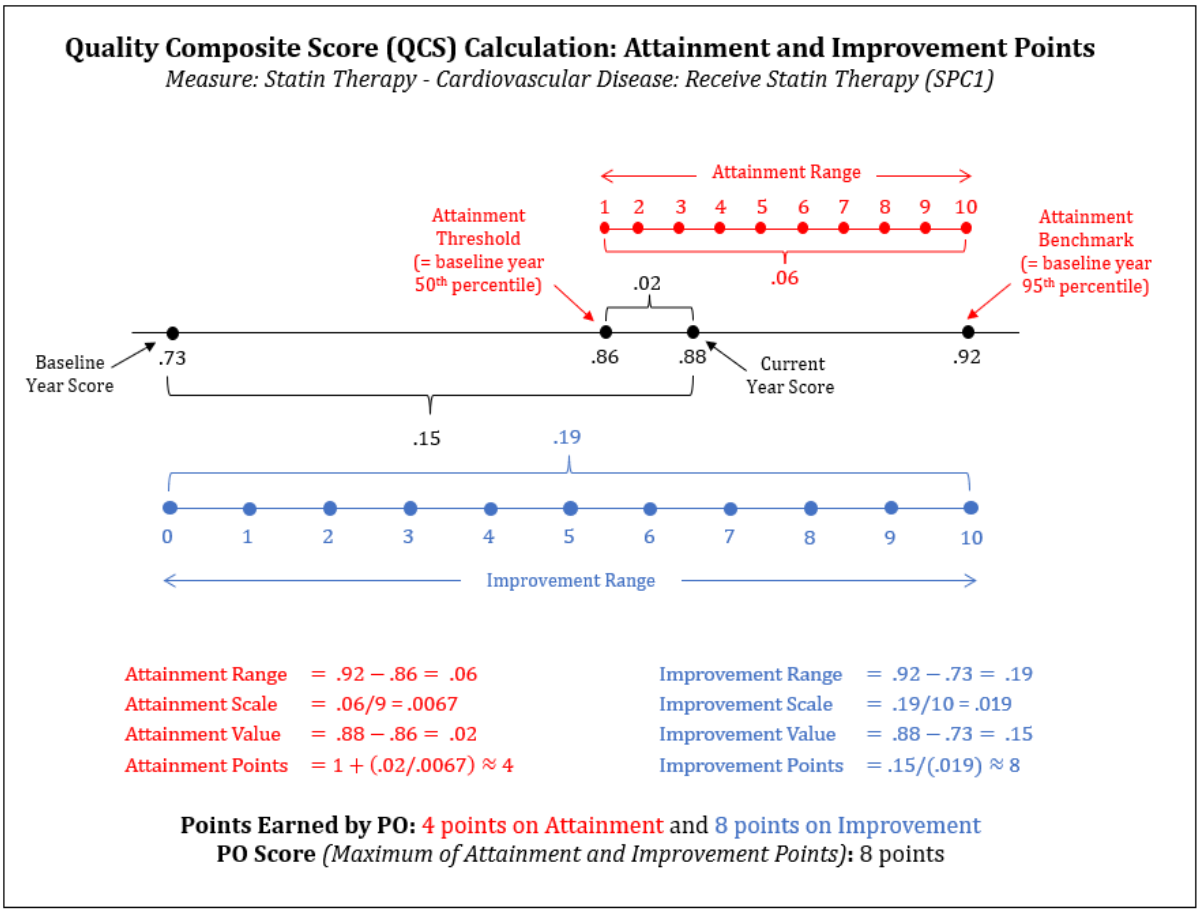
   ★ ***IHA Committee Recommendation (MY 2021 and beyond):*** *IHA committees recommend setting the attainment threshold at the baseline year's 50th percentile. The rationale underlying this decision is as follows:*

   - *Evidence suggests that the attainment threshold update would most benefit the POs performing above the median but below the 75th percentile.*
   - *An attainment threshold of the 50th percentile aligns with broader industry approaches (e.g., CMS Hospital Value-Based Purchasing Program).*

2. **Attainment benchmark:** AMP 95th percentile (including Kaiser Permanente) for the baseline (i.e., prior) measurement year. The attainment benchmark is the score needed to earn maximum attainment points for the measure.
3. **Scoring unit:** AMP quality or patient experience measure. Each measure will be assigned 0 to 10 points on both attainment and improvement. The higher of the two point values will be used for calculating the overall score

for the domain. *Note: If performance is below the 50th percentile, then at least 2 improvement points must be earned to earn an improvement score.*

4. **Domain-level scoring unit**: AMP measurement domain (clinical, patient experience, or ACI). The points earned for each measure within a domain will be summed and then translated into points towards the QCS score. *Note: The domain score is based on performance on measures for which the PO had a valid result. IHA will provide this score to health plans.*



Translating ACI Performance into Points

Calculate points earned for the ACI domain based on the percent of providers who meet the measure's requirements, as shown in the table below. The maximum number of points in this domain is 10.

Overall ACI Domain	% of Providers	Points	PO's Points for Domain-Level Score
Blood Pressure e-Measure	XY%	5	(.XY)(.05)
Depression e-Measure	YZ%	5	(.YZ)(.05)
Total Possible Points		***10***	***Sum of Section Points***

Translating Domain-Level Scoring Points into QCS

The AMP value-based incentive design uses quality as both as a performance gate and as a multiplier, which adjusts up or down the amount of shared savings incentive a PO earns. The points earned for each quality measurement domain (clinical quality, patient experience, and ACI) will be weighted into an overall PO score, out of 100 total possible points.

- **Quality Gate:** POs must meet a minimum level of quality to be eligible for shared savings or attainment incentives.
- **Quality Multiplier:** Quality adjusts a PO's shared savings and attainment incentives up or down. Higher quality POs will see payments increased; lower quality POs will see their payments reduced.

Notes

- POs are only scored on measures for which they have a valid result, so they are not "penalized" for not meeting the denominator criteria (i.e., ≥30 for clinical measures) or reliability threshold (i.e., ≥0.70 for patient experience measures) for certain measures due to their PO size or population.
- ACI is only scored on overall performance within the current year— i.e., there is no improvement scoring. The ACI domain score is the total points earned divided by the total possible points.

APPENDIX C: Full-Risk Example Calculation

To illustrate the application of the IHA value-based incentive design for full-risk POs, the example below presents a scenario for a health plan with six full-risk POs that all pass the performance gates. In this example, each PO has 10,000 member months; one of two QCS values (25 or 45); and one of three geography- and risk-adjusted TCOC amount values ($250,000 truncation per member applied).

- Budget = $105,000
- Total Membership = 60,000 member months
- Incentive per Value-Weighted Member Month *(referred to as x in the table below)*

  = Budget / Total Value-Weighted Membership

  = $105,000 / 2,100,000 member months = $0.05 per member, per month (PMPM)

	A	B	C=fn(B)	D=A*C	E	F=E*D	G=D*x	G=F*x
Example	**QCS**	**TCOC Amount***	**Cost Adjustment**	**Value Score** (cost-adjusted quality)	**Membership** (member months)	**Value-Weighted Membership**	**Incentive ($PMPM)**	**Total Incentive**
Full-Risk PO A	45	$2,895	1.2	54	10,000	540,000	$2.70	$27,000
Full-Risk PO B	25	$2,895	1.2	30	10,000	300,000	$1.50	$15,000
Full-Risk PO C	45	$3,666	1	45	10,000	450,000	$2.25	$22,500
Full-Risk PO D	25	$3,666	1	25	10,000	250,000	$1.25	$12,500
Full-Risk PO E	45	$4,437	0.8	36	10,000	360,000	$1.80	$18,000
Full-Risk PO F	25	$4,437	0.8	20	10,000	200,000	$1.00	$10,000
Total					**60,000**	**2,100,000**	**$1.75**	**$105,000**

**Geography- and risk-adjusted TCOC ($250,000 truncation per member applied)*

Calculation Steps for Full-Risk PO A

Step 1 – Apply Performance Gates

Based on the identified assumptions, we know that the PO has passed the performance gates and is eligible for an incentive.

Step 2 – Calculate QCS

The starting point for the value score calculation is the QCS. For ease of illustration, the QCS has already been calculated and is displayed in the table above. PO A's performance on the clinical quality, patient experience, and ACI measures translates into a QCS of 45.

Step 3 – Generate Value Score

The next step is to determine the PO's value score that will be used to determine the incentive amount; this is done by applying the adjustment for the PO's relative performance on geography- and risk-adjusted TCOC to the QCS. PO A's geography- and risk-adjusted TCOC is the same as the 10th percentile, so the PO will earn the maximum adjustment of 20% as recommended by the IHA committees. For POs with costs for a health plan between the 10th and 90th percentiles, the cost adjustment would be determined in a linear fashion (similar to the Quality Multiplier in the IHA incentive design for shared-risk POs).

Cost adjustment = fn(Total Cost of Care)

= fn($2,895)

= 1.2

Applying this cost adjustment to the PO's QCS yields a value score of 54.

Value Score = Quality Composite Score x Cost Adjustment

= 45 x 1.2

= 54

Step 4 – Determine Incentive Payment

To distribute the budget, the health plan determines the value-weighted membership for each PO. For PO A, this would be 540,000.

Membership-Weighted Value = Value Score x Membership

= 54 x 10,000

= 540,000

The health plan can calculate the incentive per value score unit by dividing the total budget by the sum of value weighted membership (shown above the table). In this case, incentive per value score unit is $0.05. Applying the $0.05 per value point incentive to PO A's value score of 54, we see that PO A will earn $2.70 per member month, or a $27,000 incentive total.

Incentive = Value Score x Incentive

= 54 x $0.05

= $2.70

Total Incentive = Incentive x Member Months

= $2.70 x 10,000 member months

= $27,000

APPENDIX D: Resources

Measure Set and Specifications

- AMP Measure Set outlines all measures collected in AMP, including designations for those recommended for payment and public reporting. The measure set also includes measures collected for Medicare Advantage Stars.
- AMP Program Guide and Technical Specifications includes technical measure specifications, along with data collection and reporting guidelines.

Value-Based Incentive Design

- Value-Based Incentive Design Resources

Align. Measure. Perform. (AMP) Programs

- Fact Sheet: AMP Commercial HMO
- Fact Sheet: Value-Based Pay for Performance for Physician Groups – Key Pay-for-Performance Design Decisions
- Issue Brief: Charting a Course to Value in Physician Group Payment – Key Pay-for-Performance Design Decisions

Special Thanks – IHA Technical Payment Committee

- Anil Keswani, MD, Scripps Health (**CHAIR**)
- Andres Aguirre, Sharp Health Plan
- Andrew See, Kaiser Permanente Health Plan
- Angela Chen, Blue Shield of California
- Carla Allison, Cigna
- Caroline Goldzweig, MD: Cedars-Sinai Medical Care Foundation
- David Seidenwurm, MD: Sutter Medical Group
- Jamie Phillips: NAMM California
- Jim Orchison: Health Net

- Julie Kuo, PhD: Hill Physicians Medical Group
- Linda Deaktor: MedPOINT Management
- Marcy Norenius: Meritage Medical Network
- Matthew Low: UnitedHealthcare
- Ritu Grover: Aetna
- Taylor Ballou: Blue Shield of California Promise Health Plan
- Zhongchen Ma: Anthem Blue Cross

APPENDIX E: Guidance for Incentive Design Implementation – Improvement Pathway for Shared Risk POs

Transition to Un-Normalized Risk-Adjusted ARU Measure Results for Incentive Payments

Substantive changes in the AMP population (e.g., inclusion of health plan data) can impact PO's results and their year-over-year trend due to the normalization factor that is currently applied to the risk-adjusted ARU results. As such, the Technical Payment Committee recommended that IHA transition to the use of un-normalized results for risk-adjusted ARU measures to calculate the units of improvement for improvement (shared savings) incentive calculations.

Improvement (Shared Savings) Methodology – Units of Improvement Calculation

The observed to expected (O/E) ratio for baseline and measurement year are used to calculate the units of improvement. Below are the changes to the formula starting in MY 2019.

Updated Methodology for MY 2019

- All-Cause Readmissions (PCR)

$$Unit\ of\ Improvement = (Prior\ MY\ \mathbf{Unnormalized}\ O/E\ Ratio - Current\ MY\ \mathbf{Unnormalized}\ O/E\ Ratio) \times Current\ MY\ Expected\ Rate \times (Current\ MY\ Index\ Hospital\ Stays) \div 100$$

- Emergency Department Utilization (EDU) and Acute Hospital Utilization (AHU)

$$Unit\ of\ Improvement = (Prior\ MY\ \mathbf{Unnormalized}\ O/E\ Ratio - Current\ MY\ \mathbf{Unnormalized}\ O/E\ Ratio \times Current\ MY\ Expected\ Rate \times (Current\ MY\ Member\ Years) \div 1000$$

Previous Methodology (MY 2018 and before)

- All-Cause Readmissions (PCR)

$$Unit\ of\ Improvement = (Prior\ MY\ \mathbf{Normalized}\ O/E\ Ratio - Current\ MY\ \mathbf{Normalized}\ O/E\ Ratio) \times Current\ MY\ Expected\ Rate \times (Current\ MY\ Index\ Hospital\ Stays) \div 100$$

- Emergency Department Utilization (EDU) and Acute Hospital Utilization (AHU)

$$Unit\ of\ Improvement = (Prior\ MY\ \mathbf{Normalized}\ O/E\ Ratio - Current\ MY\ \mathbf{Normalized}\ O/E\ Ratio) \times Current\ MY\ Expected\ Rate \times (Current\ MY\ Member\ Years) \div 1000$$

APPENDIX F: Log of Approved Design Changes

October 2022 Updates

- *For MY 2021, apply the Quality Gate only when assessing PO incentive eligibility; waive the TCOC Amount Gate and TCOC Trend Gate.*
- *Specific to the clinical quality and patient experience domains, set the attainment threshold at the baseline year's 50th percentile for MY 2021 and beyond.*
- *For MY 2021, waive the improvement pathway and fully utilize the attainment pathway as the basis of PO incentive payments.*
- *For MY 2021, expand the attainment targets to include the 50th percentile in addition to the 75th and 90th percentiles, with higher targets earning larger incentives.*
- *For MY 2021, utilize MY 2020 as the baseline measurement year across all applicable elements of the incentive design.*

September 2021 Updates

- Update Standard Payment Methodology for the Quality Composite Score - lower the benchmark from 75th percentile to 50th percentile to calculate attainment points earned for clinical quality and patient experience domains. Maintained the 90th percentile for attainment points calculation.
- Waived both TCOC trend and amount gates.
- Updated the improvement (shared savings) incentive design methodology to reflect a one-time adjustment for COVID impacts.
- Fully utilizing the attainment incentive design methodology to reward POs expanding on the current targets to 50th, 75th and 90th percentile of performance for all POs in the measured population. The higher the benchmark earns a larger incentive.

September 2020 Updates

- Updated units of improvement methodology to use un-normalized results for risk-adjusted utilization measures (Appendix E).

October 2019 Updates

- Use HEDIS© risk-adjusted utilization measures for health plan incentive payments.
- One-time adjustment applied to each PO's estimated Total Cost of Care Trend.

November 2018 Updates

- Transition towards HEDIS© risk-adjusted utilization and HealthPartners Total Cost of Care (TCOC) measures.
- Update to small provider organization definition.
- Guidance of incentive design implementation for small provider organizations.
- Removal of Optional ARU Adjustments to Base Incentive.

November 2017 Updates

- Guidance for MY 2016 incentive design implementation.

May 2017 Updates

- Updated Quality Gate.
- Updated weights for clinical quality, patient experience, and ACI domains.

March 2016 Updates

- Updated recommended design for full-risk POs to use standard value-based design.

November 2015 Updates

- Addition of Attainment Incentive.
- Removal of ARU Attainment Adjustment.

December 2014 Updates

- Added information on full-risk provider organization incentive design options.

May 2014 Updates

- New full-risk provider organization incentive design option.
- Recommended target adjustment for generic prescribing measures.
- Removed optional aggregated performance improvement gate.
- Clarified 90th percentile used in defining high-cost POs.

September 2013 Updates

- Note about the development of a standard target adjustment for generic prescribing measures.
- Recommended values for the optional ARU Attainment Adjustment.
- Recommended values for the optional ARU Improvement Adjustment.
- Special handling of small provider organization results to address instability.

March 2013 Updates

- Recommended values for the Total Cost of Care Trend Gate threshold, including confidence level.
- Definition of consistently high-cost provider organizations.
- Set the maximum quality multiplier at a gold standard instead of the maximum provider organization score for the year.