



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

Measurement Year 2024 Program Guide (Preliminary)

Released June 1, 2024

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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) 2024 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 2024

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 2024 AMP Technical Specifications*, released on October 9, 2023, includes draft technical specifications for all measures in the AMP program for MY 2024, and reflects applicable changes in HEDIS^{®2} *MY 2024 Volume 2: Technical Specifications* (released in August 2023).
- The *Final MY 2024 AMP Technical Specifications*, released on June 1, 2024, includes final technical specifications for all measures in the AMP program for MY 2024, and reflects applicable changes in *HEDIS MY 2024 Volume 2: Technical Specifications Update* (released in April 2024).
- The *Preliminary MY 2024 AMP Program Guide*, released on June 1, 2024, includes AMP programmatic information such as background on AMP programs, reporting guidance, and timelines for data submission.
- The *Final MY 2024 AMP Program Guide*, to be released on December 15, 2024, will include all information previously included in the *Preliminary MY 2024 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, 2024.

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
- **Equity**
 - Data Quality
 - Patient Experience
 - Appropriate Resource Use
 - Cost

MY 2024 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			✓		✓	
		Eye Exam for Patients with Diabetes	✓	✓	✓		✓	
		Glycemic Status Assessment for Patients with Diabetes <8.0%	✓		✓		✓	
		Glycemic Status Assessment for Patients with Diabetes >9.0%	✓	✓	✓		✓	
		Kidney Health Evaluation in 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	✓		✓			
		Breast Cancer Screening (ECDS measure)	✓	✓	✓		✓	
		Colorectal Cancer Screening (ECDS measure)	✓	✓	✓		✓	
		Transitions of Care: Medication Reconciliation Post-Discharge			✓ ^A			✓
Well Child Visits in the First 30 Months of Life			✓ ^A		✓ ^A			

Domain	Priority Area	Measures	Commercial HMO	Medicare Advantage*	Medi-Cal Managed Care	Non-HEDIS	Differs From HEDIS
	Maternity	Prenatal and Postpartum Care	✓ ^A		✓		
		Prenatal Immunization Status (ECDS measure)	✓		✓		
	Respiratory	Asthma Medication Ratio	✓		✓		
	Behavioral Health and Substance Use	Depression Screening and Follow-up for Adolescents and Adults (ECDS measure)	✓ ^A		✓ ^A		
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	Acute Hospital Utilization (risk adjusted measure)	✓				✓
		All-Cause Readmissions (risk adjusted measure)	✓	✓	✓		✓
		Emergency Department Utilization (risk adjusted measure)	✓				✓
Cost	Cost	Total Cost of Care	✓	✓ ^{**}	✓	✓	
Testing	Testing	Race & Ethnicity Diversity of Membership	✓ ^{***}	✓ ^{***}	✓ ^{***}		
		Pharmacotherapy for Opioid Use Disorder	✓ ^{***}		✓ ^{***}		

^A First-Year status for this measure in MY 2024 is dependent on evaluation of testing results from MY 2023.

* All Medicare Advantage measures are used by CMS in their Stars Ratings program, except for Encounter Rate by Service Type, Encounter Format, Encounter Timeliness, 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 2024 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.

[A list of health plans participating in AMP Commercial HMO for MY 2024 will be available in the Final MY 2024 AMP Program Guide, to be released December 15, 2024.](#)

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.

[A list of health plans participating in AMP Medicare Advantage for MY 2024 will be available in the Final MY 2024 AMP Program Guide, to be released December 15, 2024.](#)

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.

[A list of health plans participating in AMP Medi-Cal Managed Care for MY 2024 will be available in the Final MY 2024 AMP Program Guide, to be released December 15, 2024.](#)

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 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 **six** domains of AMP measurement: Clinical Quality, **Equity**, 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. **The Clinical Quality Domain includes the Clinical Quality measures.**
- **Equity 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. **The Equity Domain includes the Race/Ethnicity Diversity of Membership measure.**

- *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 2024 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.

Domains and Reporting Entities

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

*The Clinical Quality Domain includes one testing measure for MY 2024: **Pharmacotherapy for Opioid Use Disorder**. The Equity Domain includes one testing measure for MY 2024: **Race and Ethnicity Diversity of Membership**. All health plans and self-reporting POs are strongly encouraged to report testing measure results.

**Onpoint will generate the SUPD measure 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.

A list of health plans participating in the AMP programs for MY 2024 will be available in the Final MY 2024 AMP Program Guide, to be released December 15, 2024.

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 2024.

General Program Dates

Activity or Milestone	PO Deadline	Health Plan Deadline
Medication List Directory (MLD): MY 2024 MLD posted to NCQA website .	April 1, 2024	
Final MY 2024 Technical Specifications, and Preliminary MY 2024 Program Guide posted to the IHA website.	June 1, 2024	
PAS: Registration information emailed to POs.	September 26, 2024	
2024 Public Comment Period posted to the IHA website. <ul style="list-style-type: none"> • Call for Public Comment document for MY 2025 • Draft AMP MY 2025 Technical Specifications • MY 2025 Proposed Measure Sets 	October 7–October 25, 2024	
Audit Guidelines: MY 2024 AMP Audit Guidelines posted to NCQA and IHA website.	October 28, 2024	
MY 2024 Participation Confirmation Period: POs declare their intent to participate in the AMP programs for MY 2024 and confirm their health plan contracts.	November 6–November 26, 2024	
Final MY 2025 Measure Set posted to the IHA website.	December 15, 2024	
Final MY 2024 AMP Program Guide posted to the IHA website.	December 15, 2024	
2024 Public Comment Responses posted to the IHA website.	December 15, 2024	
Final AMP Contracts Roster (formerly AMP Master) from Participation Confirmation distributed to AMP data partners.	February 6, 2025	

AMP Data Collection and Reporting Timeline

The timelines below include major milestones for MY 2024 in the Clinical Quality, Equity, 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.

The MY 2024 timelines for *Health Plan Claims and Encounter Data Submissions to Onpoint* and *AMP Report Release Dates and Review Periods* will be available in the Final MY 2024 AMP Program Guide, to be released December 15, 2024.

Health Plan and PO Quality Data Submission (to FinThrive HealthCare, Inc.)

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, 2024	
Data Submission File Layout: MY 2024 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 13, 2025 Final File: February 10, 2025	
Q1-Q4 Encounter Data: POs that use FinThrive HealthCare, Inc. as the encounter data intermediary must submit all remaining Q4 2024 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 7, 2025	NA
Supplemental Data Collection Deadline: Organization completes and stops all nonstandard supplemental data collection and entry.	February 7, 2025	February 28, 2025
Supplemental Data Validation Deadline <ul style="list-style-type: none"> • For POs: Auditor finalizes approval of <i>all</i> supplemental data for POs. • For Health Plans: Auditor finalizes approval of <i>all</i> supplemental data for health plans. 	March 7, 2025	March 28, 2025
Organization submits preliminary rates to the auditor for review. <i>Auditors should review preliminary rates based on the current year's specifications.</i>	March 28, 2025	
Supplemental Data to Health Plans: Health plans receive the audited supplemental data files and audit results from the PO.	March 28, 2025	
Data Layout Test Files: Self-reporting POs and health plans submit data layout test files to FinThrive HealthCare, Inc.	March 17–April 21, 2025	
Self-Reporting PO review period: Self-reporting POs review all submissions before sending to auditors to ensure data validity and completeness. Note: <i>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.</i>	April 14–April 21, 2025	NA
Submission Files to Auditors: Self-reporting POs and health plans send submission files to auditors.	April 21, 2025	

Activity or Milestone	PO Deadline	Health Plan Deadline
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.	May 2, 2025	
Resubmission of Auditor-Locked Results: Self-reporting POs and health plans submit auditor-locked clinical results to FinThrive HealthCare, Inc., if needed.	October 2025	

Review and Correction of MY 2024 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 will be available in the [Final MY 2024 AMP Program Guide](#). 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. [Dates for the combined Quality Reports and Onpoint-generated Reports Questions and Appeals Period will be available in the Final MY 2024 AMP Program Guide.](#)

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 2024**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 2024 AMP Audit Review Guidelines will be available in November 2024**. 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.

Equity Domain

Adoption of the AMP Equity Domain in MY 2024 will support ongoing health equity efforts and facilitate the improvement of race and ethnicity data completeness in AMP, beyond focusing only on stratification of specific measures.

The Equity Domain includes the Race/Ethnicity Diversity of Membership (RDM) HEDIS measure, which is a testing measure for voluntary reporting in MY 2024. Health plans and self-reporting POs will voluntarily report data for the RDM measure using the Health Plan and PO Testing Data File Layout via the audited results submission to FinThrive Healthcare, Inc. IHA will use the testing measure results to evaluate the RDM measure and Equity Domain for future inclusion in the measure set, benchmarking, incentive payments, public reporting, and/or public recognition awards. There will be opportunity for Public Comment before decisions are finalized by the Technical Measurement and Program Governance Committees.

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.

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 2024 testing in the AMP program (barring issues that may impact the testing timeline). The Program Governance Committee confirmed adoption of these measures in Fall 2023 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.

Clinical Quality	• Pharmacotherapy for Opioid Use Disorder (POD).
Equity	• Race/Ethnicity Diversity of Membership (RDM).
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 **2024** for MY 2024 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.