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

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Executive Summary

About the Align. Measure. Perform. (AMP) Programs

Historically, physicians and physician organizations (POs) have received the same payment regardless of the quality of care they provide. To change this equation, in 2001, the Integrated Healthcare Association (IHA), working with California health plans and physician organizations, launched a statewide pay-for-performance initiative with a goal of creating compelling incentives to drive improvements in clinical quality and patient experience. The program's core components include: (1) a common set of measures, (2) health plan incentive payments, (3) a public report card, and (3) PO recognition awards.

While steady quality improvements were achieved, the dramatic increase in health care costs over the past decade overshadowed gains in quality. In 2010, IHA stakeholders called for modification of the existing program to reward performance on quality, cost, and utilization measures in an integrated fashion. The Align. Measure. Perform. (AMP) Commercial HMO/POS program was developed, and today includes 11 health plans and 200 California physician organizations caring for 11 million Californians enrolled in commercial HMO and POS plans.

The transition to value involved all four program components: common measures, incentive payments, public reporting, and awards. This document outlines in detail IHA's value based incentive design for health plan payments. All participating health plans, with the exception of Kaiser Permanente, use the program's performance results to pay incentives to POs. To date, nine health plans—Aetna, Anthem Blue Cross, Blue Shield of California, Cigna, Health Net, LA Care, Sharp Health Plan, UnitedHealthcare, and Western Health Advantage—have committed to transitioning to IHA's value based incentive design; seven health plans made payments using the design for measurement year 2018.

IHA Value Based Incentive Design

IHA's value based incentive design, which combines clinical quality, patient experience, cost, and resource use measures, is one of the largest alternative payment models in the country. At its core, the program is based on shared savings, adjusted for performance on quality measures. The incentive design is intended to improve quality, decrease costs, and reward providers for delivering higher-value care.

The design is upside risk only; participants can earn an incentive through shared savings but bear no downside financial risk. To be eligible to earn any share of savings, POs must first meet minimum quality and total cost of care (TCOC) standards, known as the Quality Gate and TCOC Gate. POs that do not meet both thresholds 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. Incentive amounts are summed across all measures. Any shared savings earned are divided between the health plan and the PO. To maximize the amount of incentive earned, POs must make greater improvements in resource use while simultaneously offering higher quality.

Improving resource use year to year is challenging, particularly for POs that are already relatively efficient. 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 are consistently exceeding population benchmarks for resource use. More information can be found at http://www.iha.org and questions can be sent to amp@iha.org.

Overview

Since 2001, IHA through the California P4P program has created a successful statewide performance measurement collaboration that includes uniform measures, aggregated data collection and validation, a single public report card, and a trusted governance process. The Align. Measure. Perform. (AMP) strategic initiative emerged from the California P4P program 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 physician organizations (POs) from focusing solely on rewarding quality to rewarding value by adding costs and resource use as performance components.

The IHA value based incentive design is a shared-savings model that incorporates the quality, cost, and utilization of health care services. The value based incentive design was developed in collaboration with AMP participating health plans and POs, and was approved in 2012. Starting in measurement year 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 Performance Measurement Collaborative committees—Governance, Technical Measurement, and Technical Payment. These design changes are logged for reference in Appendix G.

Incentive Design Objectives

The purpose of the IHA value based incentive design is to revitalize the AMP program against a backdrop of affordability. The objectives of this strategic initiative 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 IHA value based incentive design are intended to contribute to lower cost trends and a more competitive, value-based HMO product.
2. 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. 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: **common measure set**, **performance gates**, **incentives** based on **appropriate resource use (ARU), quality adjustments**, and summation of **incentive amounts** across measures. IHA value based incentive payments can be earned in two ways: through *shared-savings incentives* that reward year-over-year improvement and *attainment incentives* that reward continued excellence in resource stewardship. POs that both improve and achieve the attainment benchmark can earn incentives through both pathways.

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 total cost of care trend and amount below established thresholds. These standards are referred to as **performance gates,** specifically the Quality Gate and the TCOC Gates.

Shared savings are generated by PO improvements in **resource use**, based on five common measures: inpatient discharges, readmissions, emergency department (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. A PO's performance on each ARU measure is compared to population benchmarks—POs achieving and maintaining these high-performance levels are eligible for the supplemental incentive.

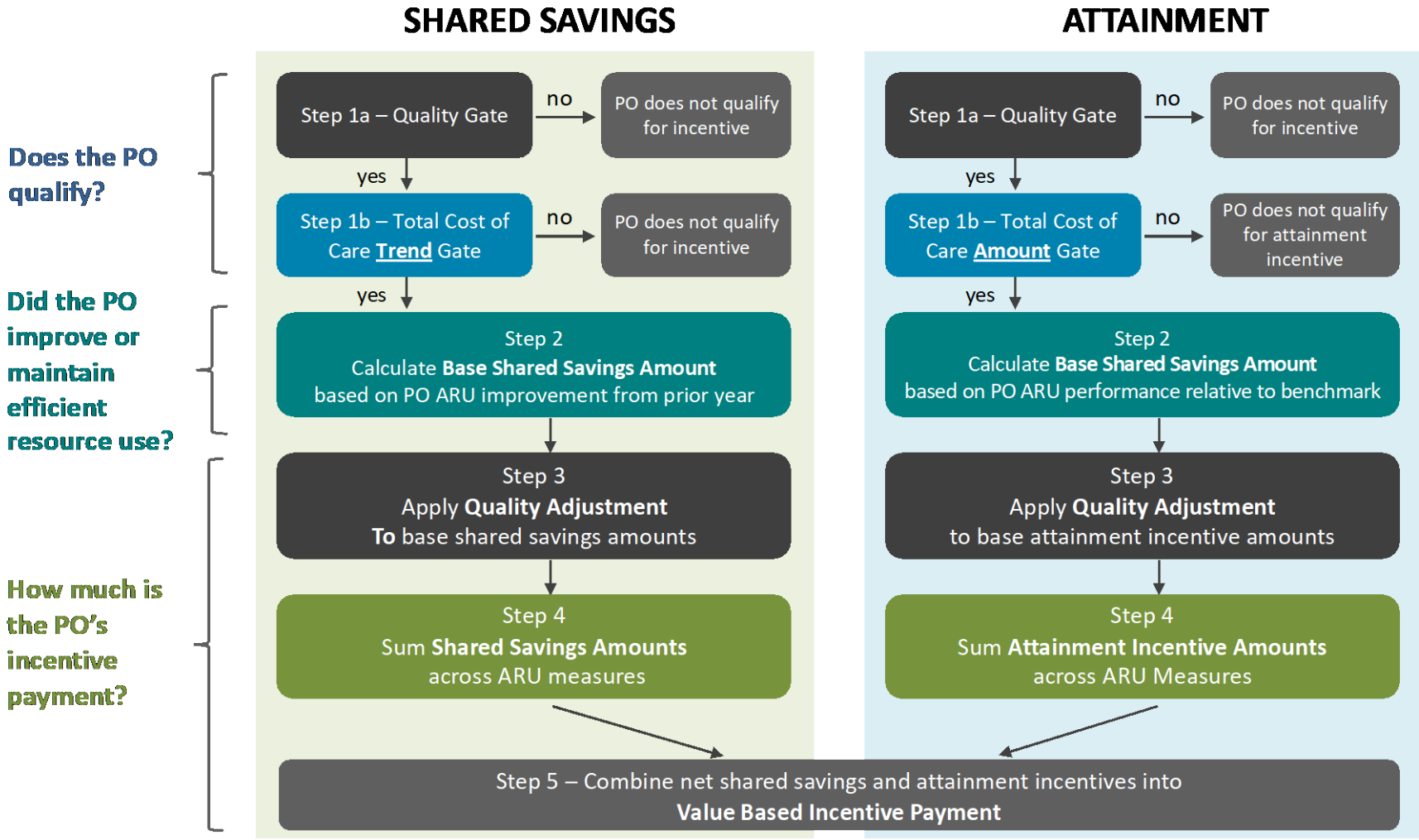
A **quality adjustment** is made to both the shared-savings and attainment incentives that increases or decreases the amounts to reflect a PO's quality performance. Finally, **shared-savings** and **attainment incentives** are summed across all five resource use measures. Each measure's shared savings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

To balance the need for standardization and adaptability, the Performance Measurement Collaborative 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
  ○ Total Cost of Care Trend Gate
▪ Quality Adjustment
▪ ARU Shared Savings Calculation
▪ ARU Attainment Incentive
	▪ Threshold/Gate Values
	▪ Multiplier Ranges/Values
	★ *Throughout the document, 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



Calculating Value-Based Incentive Payments

The core design elements—a **common measure set**, **performance gates**, **shared savings** and **attainment** based on resource use, and summation of **incentive amounts**—can be tracked across the parallel and complementary *shared-savings* and *attainment incentives*, which ultimately converge.

The *shared-savings* incentive assesses a PO's performance relative to its prior 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. The incentives are then combined; POs that both improve and meet attainment benchmarks are eligible to earn both incentives. The design, including shared savings and attainment, is outlined in detail below.

Common Measure Set

The incentives are founded 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 that cover clinical care, patient experience, and meaningful use of health IT. These measures are used as a performance gate and as an adjustment that increases or decreases a PO's incentives.
- **Appropriate Resource Use** measures capture key aspects of utilization—inpatient discharges, ED visits, readmissions, outpatient services, and generic prescribing—that contribute to the overall costs of care and are influenced by physician organization coordination and management of patient care. Improvement and attainment on these measures drive the incentive amounts.
- A **Total Cost of Care** measure comprised of actual payments associated with care for all commercial HMO/POS enrollees in a PO. The TCOC trend (i.e., percent change between years) and TCOC amount are used in the performance gates for AMP.

Step 1: Apply Performance Gates

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

POs that do not meet the Quality Gate are ineligible for any incentives. Both the Quality Gate and the appropriate TCOC Gate must be met in order to be eligible for an incentive, whether it is based on shared savings or attainment.

a. 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 meaningful use of health IT domains. A detailed description of the QCS methodology is available here. Of note, the methodology:
    - Includes all measures in these domains that are recommended for payment.

- Uses aggregated 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 (MY 2019)	Weighted Domain Score
Clinical	40	60%	24
Patient Experience	29	30%	8.7
Advancing Care Information	67	10%	6.7
Quality Composite Score			**39**

★ Performance Measurement Collaborative committee recommendation: The recommended Quality Gate threshold is set at the current year 10th percentile, which sets a bar for quality that is attainable for POs while still ensuring high performance.

b. Total Cost of Care Gates

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

- Shared savings reward 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 Shared Savings only)

This performance gate establishes a maximum TCOC Trend that POs cannot exceed to be eligible for shared savings.

- To be eligible for shared-savings incentives, a PO'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.
- The TCOC Trend is the percent change between a PO's current TCOC measurement and prior 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.

Consistently high-cost POs represent the greatest savings opportunity, and 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. ★ Performance Measurement Collaborative committee recommendation: The recommended TCOC Trend Gate threshold is based off of 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.

Year	Standard	High Cost PO
MY 2018, MY 2019	CPI+1%	CPI-1%

★ Performance Measurement Collaborative committee recommendation: Consistently high-cost POs are defined as those POs that are above the 90th percentile in geography- and risk-adjusted TCOC for a contracted health plan for both the baseline and measurement year.

TCOC Amount Gate (for Attainment Incentive only)
This performance gate establishes a maximum TCOC amount.

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

★ Performance Measurement Collaborative 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 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 shared-savings amount estimates the value of improvement on the appropriate resource use measures; 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 shared-savings and attainment incentive.

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).
- Generic prescribing – overall (GRX).

Shared Savings

The shared-savings calculation compares a PO's current and prior year utilization 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 physician organization.

- A PO's utilization target for each ARU measure is generally its own prior year performance. (See Methodological Considerations for handling of small POs and a recommended adjustment to the targets for generic prescribing.)
- 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.

★ Performance Measurement Collaborative committee recommendation: The base incentive amount for the PO starts at 50% of the shared-savings amount.

★ Performance Measurement Collaborative committee recommendation: Target is a PO's own prior year performance for the same measure; a special adjustment is offered to account for drug patent status changes.

Attainment Incentive

POs that deliver care efficiently and show excellent resource stewardship are leading the way to value. The attainment incentive increases the payment opportunity for these POs. POs that exceed the attainment benchmarks for an ARU measure for the current and previous year—demonstrating they have achieved and maintained efficient resource use—earn a supplement that is incorporated into their incentive.

- For each ARU measure, a PO's performance for the measurement year and prior 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** 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 measurement or baseline year, the PO does not earn the attainment incentive for that measure.

★ Performance Measurement Collaborative committee recommendation: 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. The higher benchmark earns a larger incentive.

Step 3: Apply Quality Adjustment to Base Incentive Amount

In addition to determining PO eligibility for incentives (see Step 1), quality also affects the incentive amount a PO earns. The quality adjustment modifies a PO's base incentives up or down. POs with higher quality will see their incentive increase, while POs with lower quality will see their incentive decrease.

a. 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 shared-savings and attainment incentives.

- A PO's quality composite score (same as described in Step 1) 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 earn nothing; above the ceiling they continue to earn the maximum quality multiplier. Between the floor and ceiling, increases in the quality composite score result in a higher multiplier and greater incentive amount.
- The quality multiplier is applied to the base shared savings and attainment amounts for each ARU measure.

★ Performance Measurement Collaborative committee recommendation: Quality multipliers of 0.65 to 1.35, which provide for a 35% increase or decrease in a PO's incentive. A PO's QCS at the 10th percentile would earn the minimum quality multiplier and a PO's QCS at the 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.

Shared Savings

The quality-adjusted shared savings (Step 3) will be positive if performance on the measure improved or negative if performance on the 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 ARU measures that declined.

Attainment Incentive

The quality-adjusted attainment incentives (Step 3) 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: Combine the Shared-Savings and Attainment Incentives

Health plans combine a PO's net shared savings (positive or negative) and net attainment incentives ($0 or positive) to determine the final incentive payment amount.

- 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 Physician Organizations

Measure results' reliability and year-over-year stability is problematic for some POs, especially small POs. Therefore, the Performance Measurement Collaborative committees recommended providing options to health plans paying on IHA results for small physician organizations. Health plans are able to provide incentives for small physician organizations using either

1. the PO all-plan aggregated results, or
2. small PO pooled results, which are provided to the plans by IHA

Small Physician Organization PO Pooling Methodology

For the small PO pooling methodology, the Performance Measurement Collaborative committees recommended calculating a weighted small PO result for the ARU measures on a plan-specific basis and using this 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 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.

Generic Prescribing

The IHA incentive design generally measures improvement against the PO's respective prior year performance for each resource use measure. For the generic prescribing therapeutic measures, the Performance Measurement Collaborative committees offered a recommended adjustment in certain instances. One potential issue this recommendation addresses is the emergence of new blockbuster drugs that may have a strong secular trend when patents expire for major brand drugs. For example, when a brand-name drug goes off patent, a PO would receive credit—and earn shared savings—for prescribing a generic drug without making any intentional change in prescribing behavior.

As a result, the committees developed a recommended approach for adjusting the measure target in instances where changes in drug classifications and availability are likely to have an across-the-board and noticeable impact. Specifically, the approach involves identifying the impacted therapeutic areas in advance and then measuring each plan's observed change for their population.

★ Performance Measurement Collaborative committee recommendation: Set the benchmark for generic improvement at the 25th percentile of the actual AMP performance for the year, determined on a plan-specific basis. Adjustment should be applied only to therapeutic areas where significant market change is identified, for both patent expirations and release of new drugs, only when the estimated adjustment aligns with the anticipated market change, and applied consistently to the benchmarks for all POs.

Full-Risk POs

Overview

One of the guiding principles for AMP is that the program is intended to be available to all POs, including full-risk POs. The amount of savings to be shared is calculated based on reductions in unnecessary resource use (such as inpatient discharges and ED visits) and adjusted by quality performance. 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

The recommended design for these physician organizations applies the Quality gate and TCOC Trend gate, and as long as the PO passes the gates, the PO would be eligible for an incentive. The recommended design then creates a value score by adjusting the quality composite score to a PO's performance on the TCOC amount. The value score is then used to distribute incentives.

1. **Apply Performance Gates**: Determine if the PO passes the AMP performance gates for quality and cost trend. If so, the PO is eligible for an incentive.
2. **Calculate Quality Composite Score:** see Standard Payment Methodology (QCS Calculation).
3. **Generate Value Score:** Apply TCOC adjustment to QCS to adjust the QSC up or down based on a PO's relative performance on the TCOC amount. The PO's TCOC performance compares a physician organization's geography- and risk-adjusted TCOC amount against PO performance for the AMP population as a whole.
4. **Determine Incentive Payment:** Value scores for POs and memberships would be used by health plans to distribute incentives across their full-risk POs.

For an example of the calculation, see Appendix B.

★ Performance Measurement Collaborative 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 10^{th} and 90^{th} percentiles of AMP PO performance on TCOC (including geography and risk adjustment).

APPENDIX A: Value Based AMP Recommended Values

To help channel variability and to serve as a basis for comparing programs across health plans, the Performance Measurement Collaborative committees have identified recommended values for the incentive methodology.

Design Element	Recommended Value	Notes/Rationale
Quality Gate	At or above current year 10th percentile.	The recommended Quality Gate threshold is set at the current year 10th percentile, which sets a bar for quality that is attainable for POs while still ensuring high performance.
TCOC Trend Confidence Level	**85%**	Using a one-sided 85% confidence level increases the certainty that a PO is correctly excluded at the TCOC Trend Gate.
TCOC Trend Gate • Standard Threshold • High-Cost POs	Standard Threshold MY 2018-2019: CPI+1% High-Cost POs MY 2018-2019: CPI-1%	The recommendation is to use a three-year average of the U.S. CPI, which would be based on the measurement year and the two years immediately preceding the measurement year. The TCOC Trend Gate for high-cost POs is set at 2 percentage points below the standard threshold.
TCOC Amount Gate	POs with geography- and risk-adjusted TCOC above the plan-specific 90th **percentile** for both 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 plan-specific 90th **percentile** for both 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 quality composite scores 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: Full-Risk Example Calculation

To highlight the application of the IHA incentive design for full-risk physician organizations, the example below presents a scenario for a health plan with six full-risk POs that all pass the Quality and TCOC Trend Gates. Each PO has 10,000 member months; one of two quality composite scores (25 or 45); and one of three Total Costs of Care (geography- and risk-adjusted).

- 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 = $0.05 PMPM

	A	B	C=fn(B)	D=A*C	E	F=E*D	G=D*x	G=F*x
Example	**Quality Composite Score**	**Total Cost of Care***	**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*

Calculation Steps for Full-Risk PO A:

Step 1 – Apply Performance Gates
Based on the identified assumptions, we know that the PO has passed both performance gates and is eligible for an incentive.

Step 2 – Calculate Quality Composite Score
The starting point for the value score calculation is the quality composite score, which, for ease of illustration, has already been calculated and is displayed in the table above. PO A's performance on the clinical quality, patient experience, and meaningful use of health IT measures translates into a composite score 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, by applying the adjustment for the PO's relative performance on geography- and risk-adjusted TCOC to the quality composite score. PO A's geography- and risk-adjusted TCOC is the same as the aggregated

10th percentile, so the PO will earn the maximum adjustment of 20% as recommended by the Performance Measurement Collaborative committees. For POs with costs for a 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 quality composite score 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 C: Resources

Measure Set and Specifications

- IHA Common 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 Manual includes technical measure specifications, along with data collection and reporting guidelines.

Incentive Design Development

- Value Based Incentive Design Benchmarks
- Standard Payment Methodology (Quality Composite Score Calculation)

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
- Fact Sheet: Total Cost of Care

Special Thanks – IHA Technical Payment Committee:

Anil Keswani, MD: *Scripps Health (**CHAIR**)*
Andres Aguirre: *Sharp Health Plan*
Carla Allison: *Cigna*
John Chan, *Blue Shield of CA*
Linda Deaktor, *MedPOINT Management*
Caroline Goldzweig, MD: *Cedars-Sinai Medical Care Foundation*
Ritu Grover: *Aetna*
Leigh Hutchins: *NAMM California*
Matthew Low: *UnitedHealthcare*
Zhongchen Ma*, Anthem Blue Cross*
Patricia Mowlavi: *Blue Shield Promise Health Plan*
Khanh Nguyen, PharmD: *Hill Physicians Medical Group*
Marcy Norenius, *Meritage Medical Network*
Jim Orchison: *Health Net*
Andrew See: *Kaiser Permanente Health Plan*
David Seidenwurm, MD, Sutter Medical Group

APPENDIX F: Guidance for MY 2018 Incentive Design Implementation

1. **MY 2018 Measures Used for Payments**

In measurement year (MY) 2017, IHA transitioned to HEDIS© risk-adjusted utilization and HealthPartners Total Cost of Care (TCOC) measures. For MY 2018, IHA recommends using the following measures for health plan incentive payments.

Measures	Rates Used for Payments
1. All-Cause Readmissions (PCR)	Risk-Adjusted Rates
2. Generic Prescribing (GRX)	Observed Rates
3. ED Visits (EDU)	Risk-Adjusted Rates
4. Acute Hospital Utilization – Discharges (AHU)	Risk-Adjusted Rates
5. Outpatient Procedure Utilization: Percent of Preferred Facility (OSU)	Observed Rates

Option for Scaling Estimated Improvement for AHU and EDU

The HEDIS© risk-adjusted utilization measures have continuous enrollment criteria which reduced the population (denominator). Since shared savings are paid on the total estimated units of improvement, reductions to the denominator of a resource use measure have the potential consequence of reducing the total improvement opportunity. Therefore, the Performance Measurement Collaborative committees recommended scaling the estimated improvement for AHU and EDU using each PO's total membership.

Option for Addressing the "Bed Day Gap" in the AHU Measure

The specifications for the AHU measure only include a risk-adjusted inpatient discharge rate, not a risk-adjusted bed day rate. Therefore, the Performance Measurement Collaborative committees recommended paying on risk-adjusted discharges. This requires health plans to update the unit price calculations to reflect discharges.

2. **One-Time Adjustment to the TCOC Trend Calculation**

Review of preliminary MY 2018 AMP Commercial HMO results surfaced that a significant increase in the population measured caused trends in the Total Cost of Care (TCOC) for all physician organizations to be higher than expected. To ensure that physician organization trends are isolated from this broader population change, the Technical Payment Committee recommended that IHA adjust the TCOC trend calculation to exclude the impact of this population change by using the unnormalized TCOC trend. This will ensure that POs are fairly assessed at the TCOC trend gate. All physician organizations will see a lower estimated TCOC trend in their final MY 2018 results and all subsequent incentive modeling provided to health plans and physician organizations.

APPENDIX G: Guidance for MY 2019 Incentive Design Implementation

Transition to Un-Normalized Risk-Adjusted Utilization 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 utilization results. As such, the Technical Payment Committee recommended that IHA transition to the use of un-normalized results for risk-adjusted utilization measures to calculate the units of improvement for shared savings incentive calculations.

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)

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

- Emergency Department Utilization (EDU) & 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)

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

- Emergency Department Utilization (EDU) & 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

September 2020 Updates

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

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 physician organization definition.
- Guidance of incentive design implementation for small physician organizations (Appendix E).
- Removal of Optional ARU Adjustments to Base Incentive.

November 2017 Updates

- Guidance for MY 2016 incentive design implementation (Appendix D).

May 2017 Updates

- Updated Quality Gate.
- Updated weights for Clinical Quality, Patient Experience, and Advancing Care Information 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 physician organization incentive design options.

May 2014 Updates

- New full-risk physician 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 physician 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 physician organizations.
- Set the maximum quality multiplier at a gold standard instead of the maximum physician organization score for the year.