Frequently Asked Questions (FAQ)
IHA Align. Measure. Perform. (AMP) Programs
April 2019

Clinical	**Encounter Rates by Service Type (ENRST)**	**Posted 4/9/2019**
Commercial HMO Medicare Advantage Medi-Cal Managed Care	**Question:** Our current logic for the ENRST *Encounter Rate 4: Laboratory/Pathology Services* is not including the encounters that have POS code 81 from the Independent Laboratory Value Set, in accordance with the AMP General Guideline 35 on page 34 of the MY 2018 AMP Manual. *For example:* A member has two claims during the measurement year on two different dates of service. Both claims have codes from the Laboratory and Pathology Services Value Set and a code from the Independent Laboratory Value Set. Claim 1 DOS: 05/05/2018 Code: 81001 - Urinalysis, Dip tick/Tablet Reagent; Automated W/O microscopy (Laboratory and Pathology Services) POS: 81 Claim Type: L Claim 2 DOS: 05/26/2018 Code: 82570 - Creatinine; Other Source (Laboratory and Pathology Services) POS: 81 Claim Type: L Should these claims be counted for the ENRST *Encounter Rate 4: Laboratory/Pathology Services* measure? **Answer:** Thank you for your question. Based on current logic and General Guideline 35, both claims do not meet the criteria for the ENRST measure due to the inclusion of the code POS 81. However, the intention of the ENRST measure is that these encounters (with code POS 81) should be included in the measure, and therefore, General Guideline 35 should not apply in this situation. For MY 2018, please include all encounters that meet the measure criteria based on the current ENRST measure specifications, even those that include POS code 81 on the claim if they meet the measure criteria. AMP staff will revise General Guideline 35 for the next version of the AMP manual to be released in September 2019.	

<table>
<tr><td>General</td><td>Self-Reporting PO Clinical Measure Data File Layout Instructions</td><td>Posted 3/27/19</td></tr>
<tr><td>Commercial HMO

Medicare Advantage

Medi-Cal Managed Care</td><td colspan="2">Question: My PO will self-report data for Commercial HMO and Medicare Advantage for MY 2018, but we will not self-report Medi-Cal data. In the MY 2018 Self-Reporting PO Clinical Measure data file layout posted on IHA.org, there are now records for Medi-Cal data. How should my PO complete the Self-Reporting PO Clinical Measure Data File Layout so it passes TransUnion validation?

Answer: As a reminder, PO self-reporting is voluntary, and does not require self-reporting in all product lines; however, POs submitting the self-reporting data file layout are required to populate all 117 DTL records in the file, even if your organization is not reporting for a specific measure or product line. This includes one record for each of the 53 clinical measure IDs for the Commercial product, one record for each of the 15 clinical measure IDs for the Medicare Advantage product and one record for each of the 49 clinical measure IDs for the Medi-Cal Managed Care product. If your physician organization chooses not to self-report a measure or measures within a specific product line, you must populate those fields with “NR” in the rate column, and with 0 (zero) in the denominator and numerator columns to ensure that your test file passes TransUnion validation. Detailed instructions for populating and submitting data files are located in the first tab of the data file layout.</td></tr>
<tr><td>General</td><td>Clinical Measure Data File Layouts</td><td>Posted 3/18/19</td></tr>
<tr><td>Commercial HMO
Medicare Advantage
Medi-Cal Managed Care</td><td colspan="2">Question: In the MY 2018 Self-Reporting PO clinical measure data file layout posted on IHA.org, there is a discrepancy between tab (2) CM Specs and tab (5) Sample PO File. Tab (2) CM Specs states that header record #6 should include “Total AMP Medi-Cal Managed Care Enrollment” but tab (5) Sample PO File reflects the Submitter E-mail Address. Can you confirm that Total AMP Medi-Cal Managed Care Enrollment should be included in the Self-Reporting PO clinical measure data file layout?

Answer: Thank you for pointing this out. Yes, the Total AMP Medi-Cal Managed Care Enrollment should be included in Tab (5) Sample PO File. For MY 2018, the Header Record for both PO samples should reflect the following format:

<table>
<tr><td colspan="8">SAMPLE PHYSICIAN ORGANIZATION CLINICAL MEASURE FILE</td></tr>
<tr><td>HDR</td><td>11111</td><td>00</td><td>16688</td><td>4121</td><td>12045</td><td>user@po1.com</td><td>2147</td></tr>
</table>

AMP staff have made this correction and released a new version of the affected files on iha.org.</td></tr>
<tr><td>General</td><td>Clinical Measure Data File Layouts</td><td>Posted 3/18/19</td></tr>
<tr><td>Commercial HMO</td><td colspan="2">Question: In the MY 2018 e-Measure Data File Layout for Non-Self Reporting POs posted on IHA.org, there is a discrepancy in tab (2) CM Specs tab and tab (5) Sample PO File. The CM specs tab does not include a field for the Medicare Advantage enrollment, but the sample tab has an extra enrollment field. Should non-SRPOs report e-Measures for the Medicare Advantage product line?

Answer: Thank you for pointing this out. The e-Measures are reported for the Commercial HMO product line only. For MY 2018, the Header Record for the non-SRPO sample should reflect the following format:

<table>
<tr><td colspan="7">SAMPLE PHYSICIAN ORGANIZATION CLINICAL MEASURE FILE</td></tr>
<tr><td>HDR</td><td>1111</td><td>00</td><td>16688</td><td>user@po1.com</td><td></td><td></td></tr>
</table>

AMP staff have made this correction and released a new version of the affected files on iha.org.</td></tr>
<tr><td>General</td><td>NCQA Certification and Audit Requirements for AMP Reporting</td><td>Posted 3/18/19</td></tr>
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Question: Given the recent changes to NCQA's certification and audit requirements, what options do health plans and POs have for AMP program reporting in MY 2019 and beyond?

Answer: This table outlines the certification and audit options for MY 2019 and beyond.

Health Plan and PO Options	MY 2019	MY 2020	MY 2021
Calculate measure results internally using **uncertified** software and undergo an audit with MSCR**	✓	✓	
Use an NCQA-certified vendor and undergo an audit without MSCR	✓	✓	✓
Calculate measure results internally using NCQA-certified software (ASCR) and undergo an audit without MSCR	✓	✓	✓

**As of MY 2019, health plans and POs may no longer use uncertified vendors to calculate AMP program measure results.

Question: Where is the current list of NCQA-certified vendors?
Answer: The list of NCQA-certified vendors is available here.

Question: Does this new NCQA certification and audit policy apply to HEDIS® health plan reporting?
Answer: Yes, the same requirements and timing will apply to HEDIS® health plan reporting.

Question: Will NCQA release sample test decks for organizations to review?
Answer: Yes, organizations may enter into a no-cost agreement to receive a sample measure test deck from a previous AMP program measurement year.

Question: When will the AMP program certification materials be finalized?
Answer: NCQA will have final materials ready no later than July 2019. Test decks will be available in early 2020.

Question: Are any AMP program measures not available for certification by a NCQA-certified vendor or ASCR?
Answer: Yes, some AMP program measures are not currently eligible for certification because of how they are collected and reported. The final list of measures available for MY 2019 certification for the AMP program will be included in the materials released no later than July 2019.

General Guidelines	**Supplemental Data**	**Posted 1/23/19** **Updated 3/18/19**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	***Note:*** *This FAQ was released for the HEDIS measure and applies to the AMP programs.* **Question:** When using supplemental data for measures that require a result, must the actual numeric result be present in the supplemental data in order to meet criteria? **Response:** Yes. For all measures that require a result, the actual numeric value of the result must be present in the supplemental data. For example, when reporting the BP control indicator of the Comprehensive Diabetes Care measure, documentation of the code 3078F alone in the supplemental data cannot be used to indicate a diastolic level that is less than 80. The actual diastolic value (e.g., 79) must be present in the supplemental data to meet criteria. It is appropriate for the approved data to be mapped to code 3078F (or applicable codes) to integrate into vendor or internal systems for measure calculation. Mapping must be reviewed and approved by the auditor. Please note that the previously released AMP FAQ included additional language about reporting numeric values for the ABA and WCC measures which did not apply to the AMP program given its policy of administrative only reporting.	
Clinical	**Adult BMI Assessment (ABA)**	**Posted 1/23/19** **Updated 3/18/19**
Medicare Advantage	***Note:*** *This FAQ was released for the HEDIS measure and applies to the AMP programs.* **Question:** Effective October 1, 2018, an ICD-10 coding guideline change related to reporting BMI allows providers to bill for BMI codes only if the member has a clinically relevant condition such as obesity. How does this change affect reporting the ABA measure? **Response:** The ICD-10 coding change affects only the Administrative Method. Following the new guidelines, a provider submits a claim with a BMI or BMI percentile code only when there is an associated diagnosis (e.g., overweight, obesity) that meets the new requirements. As a result, claims for members in the denominator whose only visit is in October, November or December of 2018 and does not have an appropriate ICD-10 code do not meet the current numerator criteria. NCQA's analysis shows that because this measure is reported primarily through the Hybrid Method, the effect will be small. This change does not affect organizations using the Hybrid Method, because only the BMI components are required, not the ICD-10 codes. Please note that POs and plans reporting this measure for the AMP program may continue to report BMI data through the use of supplemental data. Because there is no hybrid reporting for AMP, the AMP team will evaluate the impact of this change in the trending analysis.	
Testing	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)**	**Posted 1/23/19** **Updated 3/18/19**
Commercial ACO	***Note:*** *This FAQ was released for the HEDIS measure and applies to the AMP programs.* **Question:** Effective October 1, 2018, an ICD-10 coding guideline change related to reporting BMI allows providers to bill for BMI codes only if the member has a clinically relevant condition such as obesity. How does this change affect reporting the BMI percentile documentation indicator of the WCC measure? **Response:** The ICD-10 coding change affects only the Administrative Method. Following the new guidelines, a provider submits a claim with a BMI percentile code only when there is an associated diagnosis (e.g., overweight, obesity) that meets the new requirements. As a result, claims for members in the denominator whose only visit is in October,	

	November or December of 2018 and does not have an appropriate ICD-10 code do not meet the current numerator criteria. NCQA's analysis shows that because this measure is reported primarily through the Hybrid Method, the effect will be small. This change does not affect organizations using the Hybrid Method, because only the BMI components are required, not the ICD-10 codes. Please note that POs and plans reporting this measure for the AMP program may continue to report BMI data through the use of supplemental data. The AMP team will evaluate the impact of this change in the trending analysis.	
Advancing Care Information	**e-Measure reporting**	**Posted 2/15/19**
Commercial HMO	**Question:** What are e-Measures? **Answer:** e-Measures are electronic clinical quality measures ("eCQMs") that use data extracted electronically from EHRs and/or health IT systems to measure the quality of health care provided. CMS uses eCQMs in a variety of quality reporting and value-based purchasing programs.[1] eCQMs are programmed into ONC-ATCB certified (i.e., Meaningful Use compliant) EHR systems; participants should ensure that the eCQMs included in the AMP Commercial HMO measure set are activated for their EHR.	
	Question: Which e-Measures are collected for the AMP Commercial HMO program? **Answer:** AMP collects data on the following two e-Measures for AMP Commercial HMO's Advancing Care Information (ACI) domain: • *Controlling High Blood Pressure.* • *Screening for Depression and Follow-Up Plan.* Find the complete specifications for these measure on pages 165-177 of the MY 2018 AMP Program Manual. Page 163 of the manual provides instructions on how POs can report e-Measures.	
	Question: Which providers are eligible for e-Measure reporting? **Answer:** All primary care physicians (MDs and DOs), including internists, family practitioners, GPs and pediatricians participating in AMP Commercial HMO are eligible for e-Measure reporting. E-Measures are not collected for any other AMP program at this time. Optional exclusions may apply. Refer to page 164 of the MY 2018 AMP Program Manual.	
	Question: What are the e-Measure reporting requirements for the AMP Commercial HMO program? **Answer:** E-Measure reporting is voluntary for self-reporting and non self-reporting POs. POs who self-report commercial HMO data and would like to report the e-Measures should include e-Measure results in the clinical data file layout posted by IHA and submitted to TransUnion. POs who do **not** self-report are also encouraged to report the e-Measures using the e-Measure data file layout for non self-reporting POs, posted by IHA and submitted to TransUnion. The AMP program collects two rates for each e-Measure: Rate 1: Percent reportable: *The percentage of providers in a PO who can report the e-Measure from their EHR.* • Rate 1 is intended to assess the percentage of eligible providers in a PO who can successfully report the e-Measure from their EHR (i.e., "reporting capability"). An eligible provider with reporting capability can review and share patient-level numerators and denominators with their PO to be aggregated across the PO. Alternatively, a PO with reporting capability has access to all eligible PCP e-	

[1] https://ecqi.healthit.gov/ecqms

	Measure data and can generate a report representative of providers in their PO. Rate 2: PO-level aggregated performance. *For providers who can report the e-Measure, the aggregated patient numerator and denominator.* • Rate 2 assesses, for eligible PCPs with e-Measure reporting capability (PCPs who make up the Rate 1 numerator), the aggregated patient numerator and denominator across the PO (e.g., the aggregated numerator, denominator, rate of the Controlling Blood Pressure e-Measure). • The PO must be able to access the eligible PCP e-Measure numerators and denominators and report at the PO level and the aggregated PO rate must be >0.	
	Question: How are e-Measures collected for the AMP program? **Answer:** IHA is not prescriptive about how POs collect data for the e-Measures. POs using a common, integrated EHR may be able to generate an e-Measure report across the PO. Some POs may work with a data vendor to extract the required data; others may use surveys to collect PCP data from individual providers. e-Measure data should be included in the appropriate data file layouts and submitted to TransUnion per the data collection and reporting timeline on pages 7-9 of the MY 2018 AMP Program Manual. Self-reporting POs should use the PO Clinical Measure Data File Layout to report the e-Measures; non self-reporting POs should use the e-Measure data file layout available on the Data Collection & Submission page of IHA.org.	
	Question: How are e-Measures scored for incentive payment purposes? **Answer:** AMP e-Measures include two rates; Rate 1 is recommended for payment and Rate 2, while required for reporting, is an information only rate. To receive credit for the e-Measures, POs must submit valid rates (greater than zero) for both Rate 1 and Rate 2. If a PO indicates in Rate 1 that a percent of providers in the PO are able to report the e-Measure from their EHR, but the PO cannot report a valid numerator and denominator for Rate 2, then the e-Measure is considered not reportable and the PO will receive a score of zero for Rate 1. The ACI domain accounts for 10% of the Quality Composite Score in MY 2018 AMP Commercial HMO reporting. POs who do not submit valid e-Measure results will not earn points for the ACI domain in their Quality Composite Score, which is used for payment.	
	Question: How should e-Measure rates be calculated? **Answer:** Refer to page 164 of the MY 2018 AMP Program Manual for an example of the two rates for the *Controlling High Blood Pressure* e-Measure.	
General	**Participating Health Plans**	**Posted 2/15/19**
Commercial ACO	**Question:** There is a discrepancy in the AMP manual: UnitedHealthcare is listed as participating in AMP Commercial ACO reporting (p. 3) but is not listed under the AMP Commercial ACO measurement section (p. 6). **Answer:** UnitedHealthcare is not participating in AMP Commercial ACO reporting for MY 2018 as of the December 1, 2018 publication of the MY 2018 AMP Program Manual. The MY 2019 AMP Program Manual will clarify plan participation across product lines.	

Clinical	**Cervical Cancer Screening (CCS)**	**Posted 2/15/19**
Commercial HMO Commercial ACO Medi-Cal Managed Care	**Question:** In the AMP manual, the continuous enrollment period for CCS is the measurement year and the two years prior for both Commercial HMO and Medi-Cal Managed Care. It is the same for HEDIS, but for Medicaid, the enrollment period is only the measurement year. This isn't noted in "modifications from HEDIS." Is this a modification, or should the continuous enrollment criteria align with HEDIS? **Answer:** The AMP CCS continuous enrollment criteria for Commercial HMO and Medi-Cal Managed Care should align with the criteria for HEDIS Commercial and Medicaid reporting. The MY 2019 AMP Program Manual will revise the continuous enrollment criteria to align with HEDIS. Note that the AMP Commercial ACO continuous enrollment criteria will remain aligned with the HEDIS Commercial criteria.	
Clinical	**Concurrent Use of Opioids and Benzodiazepines**	**Posted 2/15/19**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	**Question:** The COB measure updates highlight continuous enrollment through the measurement year, with one allowable gap, but this is not concurrent with the information in the *Continuous Enrollment and Allowable Gap* section of the specifications. Which rule should plans and POs follow? **Answer:** Plans and POs should follow the continuous enrollment criteria in the measure updates section of the COB measure specification on page 155 of the MY 2018 AMP Program Manual. Continuous enrollment criteria for the COB measure specifications should be the measurement year, with one allowable gap. The MY 2019 AMP Program Manual will correct the error.	
Audit	**Audit Roadmap**	**Posted 1/23/19**
Commercial HMO Medicare Advantage Medi-Cal Managed Care	**Question:** For the AMP MY 2018 Roadmap, is the last part of question 5.2W in Section 5, "Describe how you ensure these data are duplicated." stated correctly? **Answer:** No. This question should read, "Describe how you ensure these data are NOT duplicated." NCQA will update this in the MY2019 Roadmap.	
Clinical	**Statin Therapy for Patients With Diabetes (SPD)**	**Posted 1/23/19**
Commercial HMO Commercial ACO Medi-Cal Managed Care	**Question:** The AMP version of the SPD measure is specified for the Commercial HMO/POS, Commercial ACO and Medi-Cal Managed Care product lines only but includes exclusions for the Medicare product. Should the AMP version of the SPD measure include exclusions for Medicare members 66 years of age and older enrolled in an I-SNP or living long-term in an institution? **Response:** The AMP version of the SPD measure specification was updated to align with the HEDIS specifications, which include Medicare reporting. However, this exclusion should have been removed from the AMP measure specification because the SPD measure is not reported for AMP Medicare Advantage. We will make this change for the release of the MY 2019 AMP Program manual in September 2019.	

General Guidelines	**Death as an Exclusion in HEDIS**	**Posted 1/23/19**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	***Note:*** *This FAQ was released for the HEDIS measure and applies to the AMP programs.* **Question:** Is death a valid exclusion for HEDIS measures? **Response:** Yes. Members who are deceased are considered disenrolled. In most cases, deceased members do not meet the measure's Eligible Population criteria (e.g., Continuous Enrollment and Anchor Date requirements) and so they are not included in the measure denominator. However, members who meet the continuous enrollment criteria remain in the measure. For example, when reporting the Osteoporosis Management in Women Who Had a Fracture (OMW) measure, if a member had a fracture on May 1 and the member died on December 1, s/he is still considered enrolled during the continuous enrollment period (12 months [1 year] before the IESD through 180 days [6 months] after the IESD) and must remain in the measure. NCQA is currently evaluating death as an exclusion. Changes and updates will be made in HEDIS 2020 *Volume 2 Technical Specifications.* NCQA is currently evaluating death as an exclusion and any changes will be made in the HEDIS 2020 Volume 2 Technical Specifications.	
Clinical	**Comprehensive Diabetes Care (CDC) - Eye Exam**	**Posted 1/23/19**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	***Note:*** *This FAQ was released for the HEDIS measure and applies to the AMP programs.* **Question:** If documentation in a 2018 visit note indicates “No Diabetic Retinopathy as of Ophtho note on 9/2017,” does this meet criteria as a negative retinal exam? **Response:** Yes. This meets criteria for reporting because the documentation indicates that the eye exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed was within the appropriate time frame and the results are present (a negative retinal exam in the year prior to the measurement year).	
Clinical	**Controlling High Blood Pressure (CBP)**	**Posted 1/23/19**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	***Note:*** *This FAQ was released for the HEDIS measure and applies to the AMP programs.* **Question:** The HEDIS Controlling High Blood Pressure measure includes optional exclusion criteria under the Hybrid Method. May organizations apply optional exclusion criteria for the Administrative methods in AMP? **Response:** Yes. The intent is to allow organizations to apply the optional exclusion for both the Administrative and Hybrid specifications. When using the Administrative Method, organizations must use the codes in the value sets to identify members who meet optional exclusion criteria. Keep in mind that all exclusions are subject to auditor review.	

Clinical	**Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)**	**Posted 11/15/18**
Medicare Advantage	***Note:*** *This FAQ was released for the HEDIS measure and applies to the AMP programs.* **Question:** If a member is included in the ART measure due to a rule-out diagnosis, may the member be removed from the denominator based on medical record documentation indicating an incorrect diagnosis of rheumatoid arthritis? **Response:** No. Members may not be removed from HEDIS measures due to billing errors. HEDIS and AMP do allow removal of "valid data errors" if they can be substantiated through medical record documentation; however, this applies only to hybrid measures which are not included in the AMP Programs. Because the ART measure is administrative only, the use of valid data errors is not permitted, nor may supplemental be used as a substitute for claims data (to correct billing errors) or to identify valid data errors.	
Clinical	**Use of Opioids At High Dosage (UOD)**	**Posted 11/15/18**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	***Note:*** *This FAQ was released for the HEDIS measure and applies to the AMP programs.* **Question:** Why is buprenorphine excluded from the *Use of Opioids at High Dosage* (UOD) measure? **Response:** UOD requires the conversion of all dispensed opioids into morphine milligram equivalents (MME). The most current MME conversion file, published by the Centers for Disease Control and Prevention, removes buprenorphine, a partial opioid agonist, and states that the drug is not likely to be associated with overdose in the same dose-dependent manner as pure opioid agonists. NCQA removed it from the UOD measure in HEDIS 2019. This change aligns with the decision made by the Pharmacy Quality Alliance, the organization that developed the measure from which UOD was adapted for use in HEDIS. For AMP MY 2018, Onpoint will run the UOD measure off health plan pharmacy claims data submission. POs and Health plans are not expected to report this measure.	
General Guidelines	**Members in Hospice**	**Posted 11/15/18**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	***Note:*** *This FAQ was released for the HEDIS guideline and applies to the AMP programs.* **Question:** Does a member enrolled in palliative care meet criteria for the hospice exclusion outlined in General Guideline 15? **Response:** Palliative care is not the same as hospice care because it can begin when a patient is diagnosed or is undergoing treatment and may not indicate being near end of life. The hospice exclusion requires evidence that the member is receiving hospice services. Documentation that a member is in palliative care is not part of the exclusion.	