Integrated Healthcare Association

Frequently Asked Questions
Align. Measure. Perform. (AMP) Programs

February 2024

Clinical Quality Domain	Colorectal Cancer Screening (COL)	Posted 2/15/2024
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** For MY 2023 reporting, is documentation of "Colon Screening," "Colon Screen" or "Colorectal Cancer Screening" sufficient to be considered an FOBT if it was completed during the measurement year? **Response:** Yes. Documentation of "Colon Screening," "Colon Screen" or "Colorectal Cancer Screening," with screening dates during the measurement year, could indicate an FOBT, the least invasive test that would use this limited documentation. Because AMP is administrative only, medical record data is considered supplemental data. Keep in mind that supplemental data must meet the supplemental data requirements outlined in General Guideline 29 in the AMP MY 2023 Technical Specifications. Supplemental data requires auditor review and approval.	
Clinical Quality Domain	**Colorectal Cancer Screening (COL)**	**Posted 2/15/2024**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** For MY 2023 reporting, is documentation of "c-scope," "colo" or "colon" sufficient to be considered a colonoscopy? **Response:** No. Documentation of "c-scope," "colo" or "colon" alone is not specific enough to be considered evidence of a colonoscopy. Because AMP is administrative only, medical record data is considered supplemental data. Keep in mind that supplemental data must meet the supplemental data requirements outlined in General Guideline 29 in the AMP MY 2023 Technical Specifications. Supplemental data requires auditor review and approval.	
General	**FI-SNPs, HI-SNPs, IE-SNPs and AMP Reporting**	**Posted 2/15/2024**
Medicare Advantage	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** For MY 2023 and MY 2024, Are Facility-Based Institutional SNPs (FI-SNPs), Hybrid Institutional SNPs (HI-SNPs) and Institutional Equivalent-SNPs (IE-SNPs) treated the same as I-SNPs when reporting AMP? **Response:** Yes. FI-SNPs, HI-SNPs, and IE-SNPs should be treated the same as I-SNPs for reporting. Because they are all types of I-SNPs, they are included in the I-SNP exclusion, and are excluded when I-SNPs are excluded.	

General	MY 2024 Measure Set and Measure Specification Discrepancies	Posted 2/15/2024
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** There are discrepancies between the Final MY 2024 AMP Measure Set published on December 13, 2023, and the Draft MY 2024 AMP Technical Specifications published on October 9, 2023. Why do these discrepancies exist, and how should they be reconciled? **Response:** The AMP MY 2024 measure set was not finalized before the publication of the Draft MY 2024 AMP Technical Specifications on October 9, 2023. Based on public comment and IHA committee approval, additional measures were retired from the Final MY 2024 AMP measure set published December 13, 2023. Organizations should refer to the MY 2024 AMP Measure Set posted on the IHA website for the final list of measures by product line for MY 2024: https://www.iha.org/performance-measurement/amp-program/measure-set/. The following retirements will be reflected in the Final MY 2024 AMP Technical Specifications, which will be published on June 1, 2024: • Proportion of Days Covered by Medications (Renin Angiotensin System Antagonists, Statins, and Diabetes All Class indicators) from the Commercial HMO/POS and Medi-Cal Managed Care product lines. (This measure will still be reported for the Medicare Advantage product line.) • Statin Therapy for Patients with Cardiovascular Disease from the Commercial HMO/POS and Medi-Cal Managed Care product lines. (This measure will still be reported for the Medicare Advantage product line.) • Statin Therapy for Patients with Diabetes from the Commercial HMO/POS and Medi-Cal Managed Care product lines. • Generic Prescribing from the Commercial HMO/POS and Medi-Cal Managed Care product lines. • Hospital Average Length of Stay from the Commercial HMO/POS and Medi-Cal Managed Care product lines. • Outpatient Procedures Utilization – Percent Done in Preferred Facility from the Commercial HMO/POS and Medi-Cal Managed Care product lines.	
General Guidelines	**MY 2023 Race and Ethnicity Stratifications Audit Requirements**	**Posted 1/15/2024**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** Are there new audit requirements for race and ethnicity stratification reporting for MY 2023? **Response:** No. The AMP Audit Review Guidelines do not include new requirements for reporting race and ethnicity. Consistent with MY 2022, these data are addressed in the AMP Roadmap. Auditors must confirm that organizations provide a complete Roadmap response, and review all attachments describing data flow, layout, and transformation. Roadmap Section 5, Question 5.3J requires organizations to describe the sources they use, their processes for disaggregating race and ethnicity fields, their data source reconciliation and prioritization processes and the percentage of members with available data.	
Clinical Quality Domain	**Childhood Immunization Status (CIS)**	**Posted 1/15/2024**
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** Will the 3-dose-series Prevnar 20 (PCV20) pneumococcal vaccine be added to the vaccines supported by the CIS-Pneumococcal Conjugate indicator for MY 2024? **Response:** We anticipate that PCV20 will be added to the CIS value sets in the AMP MY 2024 Final Technical Specification scheduled for release on June 1, 2024.	

	Although the PCV20 vaccine is not included in the measure for MY 2023, the measure steward, NCQA, does not anticipate this will impact performance. The measure denominator only includes children who were at least 18 months old and expected to have already completed the pneumococcal series by June 2023 (the month when ACIP recommended PCV20).	
General	**Health Plan and PO Quality Data Submission Timeline**	**Posted 1/15/2024**
Commercial HMO/POS	**Question:** In the *Health Plan and PO Quality Data Submission (to FinThrive HealthCare, Inc.)* timeline in the Final MY 2023 AMP Program Guide, it is noted that the deadline for submitting the Advancing Care Information (ACI) e-measures for MY 2023 is May 3, 2024. However, the MY 2023 AMP Program Guide also notes that the ACI Domain was retired for MY 2023. Which is correct? **Response:** This is an error in the *Health Plan and PO Quality Data Submission* timeline in the Final MY 2023 Program Guide. The ACI Domain was retired for MY 2023, and self-reporting POs are no longer required to submit results for the eCBP and PREV-12 e-measures.	
Clinical Quality Domain	**Chlamydia Screening in Women (CHL)**	**Posted 12/15/2023**
Commercial HMO/POS, Medi-Cal Managed Care	**Question:** What are the changes to the AMP MY 2023 VSD re-released on November 30, 2023? **Response:** The NCQA coding team recently identified that some LOINC codes in the Chlamydia Tests Value Set were inadvertently removed from the AMP MY 2023 Value Set Directory released on June 1, 2023. No other value sets were affected. As a result, the AMP MY 2023 VSD was re-released on the NCQA Store on November 30, with the addition of the following 4 LOINC codes to the Chlamydia Tests Value Set: • 21613-5 (Chlamydia trachomatis DNA [Presence] in Specimen by NAA with probe detection) • 43304-5 (Chlamydia trachomatis rRNA [Presence] in Specimen by NAA with probe detection) • 43404-3 (Chlamydia trachomatis DNA [Presence] in Specimen by Probe with signal amplification) • 4993-2 (Chlamydia trachomatis rRNA [Presence] in Specimen by Probe) AMP participants will need to re-download the AMP MY 2023 VSD (by going to the "My Downloads" section of My NCQA) and re-certify the MY 2023 CHL measure by January 15, 2024.	
General Guidelines	**Definition of "Unknown" Reporting Category for Race and Ethnicity Values**	**Posted 12/15/2023**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** When can organizations report race and ethnicity as an "Unknown" value? **Response:** "Unknown" race and ethnicity values indicate missing data. Two criteria must be met to report "Unknown": 1. There is no recorded value, and 2. The organization did not receive a declined response from the member. Starting in MY 2023, all "Unknown" values must be attributed to an unknown data source. This is a change from MY 2022, when "Unknown" values were attributed to an indirect data source.	
General Guidelines	**Data Source for "Asked But No Answer" Reporting Category**	**Posted 12/15/2023**

Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** To what data source should organizations attribute the "Asked But No Answer" race and ethnicity reporting category? **Response:** The "Asked But No Answer" reporting category reflects members who were asked for race or ethnicity data, but who declined to provide a response. This reporting category must be attributed to a direct data source because the members self-reported by declining to answer.	
General Guidelines	**Sources with Populated Race or Ethnicity Values of "Unknown" or "Two or More Races"**	**Posted 12/15/2023**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** How should organizations handle data sources with values of "Unknown" or "Two or More Races"? **Response:** The measure steward, NCQA, strongly discourages using "Unknown" and "Two or More Races" response categories when collecting race and ethnicity data. When possible, organizations should instead use and encourage alternatives such as: • "Other" or "None of the above" response options for members who are unsure of their race or ethnicity. • The ability to select multiple race values for members with two or more races. If "Unknown" or "Two or More Races" are populated values in sources where health plans and self-reporting POs cannot improve response terms/options, they can be mapped to the "Some Other Race" reporting category.	
General Guidelines	**Codes for Race and Ethnicity Stratification (RES)**	**Posted 11/15/2023**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** For MY 2023 and MY 2024 reporting, are LOINC codes used to identify race and ethnicity? **Response:** No. Codes to identify race and ethnicity resemble some LOINC codes (i.e., the same format), but are derived from a code system developed by the U.S. Centers for Disease Control and Prevention (CDC). The code is the same across terminologies in multiple instances. The measure steward, NCQA, recommends that organizations establish data quality controls to avoid inadvertent data reporting errors. For example, "2106-3" could result in errors if used incorrectly: • 2106-3 = "White" (CDC Race and Ethnicity) • 2106-3 = "Choriogonadotropin (pregnancy test) [Presence] in Urine" (LOINC)	
General Guidelines	**AMP Roadmap documentation requirements for auditors**	**Posted 11/15/2023**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** What AMP Audit Roadmap documentation is required by reporting entities for data sources provided from an aggregator (e.g., health information exchange)? **Response:** It depends: • For data streams provided by aggregators with a current approved validation status in the NCQA Data Aggregator Validation program, only Roadmap Section 4 from the reporting entity (i.e., health plan or self-reporting PO) is required.	

	• For all other data streams provided by aggregators that are not validated in the DAV program, a Roadmap Section 4 from the reporting entity and Section 4a from the aggregator are required. NCQA maintains an online directory of entities with validated data streams.	
Clinical Quality Domain	**Cervical Cancer Screening (CCS)**	**Posted 11/15/2023**
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** In MY 2024, the Cervical Cancer Screening (CCS) measure includes the following criteria to identify members recommended for routine cervical cancer screening: • Administrative Gender of Female (AdministrativeGender code F) any time in the member's history. • Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) any time in the member's history. • Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code Female-typical) during the measurement year. What data sources can be used to identify these members? **Response:** When reporting CCS, use only administrative data (Administrative Gender of Female [AdministrativeGender code F] any time in the member's history) to determine members recommended for routine cervical cancer screening. Where supplemental data may be used for CCS remains the same for MY 2024. Supplemental data may not be used for denominator criteria, except in required exclusions. The second and third bullets will be removed from the CCS measure in the Final AMP MY 2024 Technical Specifications.	
Clinical Quality Domain	**Cervical Cancer Screening (CCS)**	**Posted 11/15/2023**
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** How should allowable gaps be evaluated when there is a leap year? For example, if the year prior or 2 years prior to the measurement year is a leap year, should the allowable gap calculation include all the days in the calendar year that is 2 years prior to measurement year, but falls outside of the 730 days prior to the measurement year? **Response:** No, if there are days in the calendar year that fall outside of the 730 days prior to the measurement year they should not be included in the continuous enrollment criteria or counted towards the allowable gap days. Only the period covered by continuous enrollment (e.g., January 2–December 31, 2025 for AMP MY 2025 reporting) should be used when assessing the allowable gap. The years of enrollment for allowable gap evaluation should consist of 365 periods. For example, not having coverage on January 1, 2023, does not count as a gap in enrollment for calendar year 2023 for AMP MY 2025 reporting. The following periods should be used for allowable gap evaluation: • Year 1: January 2, 2023–January 1, 2024 • Year 2: January 2, 2024–December 31, 2024 • Measurement year: January 1–December 31, 2025	
Clinical Quality Domain	**Excluding Laboratory claims (claims with POS code 81)**	**Posted 11/15/2023**
Commercial HMO/POS, Medicare Advantage,	*Note: This FAQ was released for HEDIS and applies to the AMP programs.*	

Medi-Cal Managed Care	**Question:** For MY 2024, will instructions to exclude laboratory claims (claims with POS code 81) be added to additional measures and value sets in the Final AMP MY 2024 Technical Specifications? **Response:** Yes. We anticipate the laboratory claim exclusion will be added to the following measures and value sets in the Final AMP MY 2024 Technical Specifications, which will be released June 1, 2024: AMR: Step 2 of the event/diagnosis (Asthma Value Set) GSD: Numerators (HbA1c Test Result or Finding Value Set) EED: Event/diagnosis (Diabetes Value Set) OMW: Step 2 of the event/diagnosis (Fractures Value Set) DSF-E: Exclusions 1 (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set; Depression Value Set)	
Digital Measure Packages	**ECDS Measures (BCS-E, COL-E, DSF-E, PRS-E)**	**Posted 10/13/2023**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** The AMP digital measure packages for MY 2024 include "Explanation of Benefit" (EOB) criteria. What does that mean? **Response:** Although the digital measure logic references "Explanation of Benefit (EOB)," this is not referenced as a data source in the MY 2024 AMP Technical Specifications. In FHIR, the EOB resource represents claims that have been adjudicated, and includes data elements from both Claim and ClaimResponse. The digital logic was written to include the Claim/ClaimResponse resource for claims that are still processing; the ExplanationOfBenefit resource is for claims that are adjudicated.	
Clinical Quality Domain	**Kidney Health Evaluation for Patients With Diabetes (KED)**	**Posted 10/13/2023**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** What is the intent of removing LOINC code 32294-1 from the Urine Albumin Creatinine Ratio Lab Test Value Set in MY 2024? **Response:** The KED measure provides actionable information for chronic kidney disease identification and management. Per the measure steward, NCQA, general guidance from our experts is that tests included in the measure should align with guideline recommendations from the American Diabetes Association and the National Kidney Foundation. For this reason, only quantitative uACR tests are allowed and semi-quantitative tests are not considered measure compliant. Removing LOINC code 32294-1 from the value set maintains these coding parameters.	
Patient Experience Domain	**Patient Assessment Survey (PAS)**	**Posted 8/15/2023**
Medi-Cal Managed Care	**Question:** What criteria are used when determining which Medi-Cal POs' Patient Assessment Scores (PAS) scores are included in the AMP program? **Response:** Beginning in MY 2022, to address ongoing concerns with low PAS score reliability and subsequent exclusion of results for Medi-Cal groups, PBGH and IHA have decided to update the methodology for determining which Medi-Cal POs' scores to include in the AMP program. The updated methodology for MY 2022 and beyond will use a 'minimum N approach' – setting a reasonable minimum sample size (N) for Medi-Cal POs while also using a two-	

	year roll up of scores, without considering reliability. This approach will allow for most of the Medi-Cal groups' results to be included in AMP. There is also precedent for implementing the minimum N approach by NCQA and other survey programs. For MY 2022, N is set to 100. These changes to Medi-Cal do not affect the PAS Commercial HMO PO scoring methodology, which will remain unchanged from previous measurement years.	
Onpoint Data Submission Guide (DSG)	**MY 2023 DSG Clarifications**	**Posted 8/15/2023**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** Will the Onpoint Data Submission Guide (DSG) be updated to include the clarifications previously communicated through the AMP Technical FAQs? **Response:** For MY 2023, IHA released an updated version of the Onpoint DSG which included clarifications previously communicated through the AMP Technical FAQs. This resource is available on iha.org and is referred to as IHA/Onpoint Data Submission Guide Element Schedule & Specifications version 7.2.	
Onpoint Data Submission Guide (DSG)	**TC009 – Inpatient Facility (Maternity) FFS Cost**	**Posted 8/15/2023**

Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question**: How should bill type 084x (freestanding birthing centers) be incorporated into the Inpatient Facility (Maternity) FFS Cost field?
	
	Response: Organizations should include the following spending in TC009:
	• All spending associated with Bill Type 084x, regardless of revenue code or diagnosis code
	• For claims with Bill Type codes under the listed DSG values (011x, 012x, 041x, 042x), all spending associated with the following:
	  ○ Revenue codes listed under Maternity Value Set
	  ○ Diagnosis Codes listed under Maternity Diagnosis Value Set	

Clinical Quality Domain	**Statin Use in Persons with Diabetes (SUPD)**	**Posted 7/14/2023**
Medicare Advantage	**Question:** Is the T46.6X5A SUPD exclusion code (Value Set: RHABDOMYOLYSIS_MYOPATHY_2022) still valid for MY 2023? **Response:** Per the measure steward, PQA, the ICD-10 code T46.6X5A (Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs, initial encounter) was removed from the rhabdomyolysis/myopathy exclusion value set for the MY 2023 SUPD measure. The value set titled "RHABDOMYOLYSIS_MYOPATHY_2022" was inadvertently included in the MY 2023 PQA Value Set released for AMP on June 1, 2023 and should be disregarded for MY 2023 reporting. Organizations are expected to reference ONLY the "RHABDOMYOLYSIS_MYOPATHY" value set for MY 2023 reporting.	
Clinical Quality Domain	**Cervical Cancer Screening (CCS) and Cervical Cancer Overscreening (CCO)**	**Posted 7/14/2023**
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** In MY 2023, the CCS and CCO exclusion for hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix is now a required exclusion. Does documentation of a hysterectomy in combination with documentation that the patient no longer needs Pap testing/cervical cancer screening sufficient to meet criteria as a required exclusion for AMP MY 2023 reporting?	

	Response: No. Members with documentation of "hysterectomy" and documentation indicating that they no longer need Pap testing/cervical cancer screening must remain in the measure for MY 2023 reporting. Members with documentation of a "vaginal pap smear" and documentation of "hysterectomy" must also remain in the measure for AMP MY 2023 reporting. There must be evidence (claims data using the value sets in the specification or medical record documentation as supplemental data) of a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix in order to meet required exclusion criteria for MY 2023 reporting. Documented "vaginal hysterectomy" or "complete/total/radical hysterectomy" that matches a definition in applicable value sets may be used to meet criteria, subject to auditor approval.	
Appropriate Resource Use Domain	**Total Cost of Care (TCOC)**	**Posted 6/15/2023**
Commercial HMO/POS	**Question:** Are TCOC risk scores normalized for the Commercial HMO population? **Response:** To support trending of the TCOC results year-over-year, beginning in MY 2022, IHA and Onpoint will no longer normalize TCOC risk scores for the AMP Commercial HMO population. The following language in Step 1 of the Risk-Adjustment Determination section of the TCOC measure specification was removed from the Final AMP MY 2023 Technical Specifications and should be disregarded in the AMP MY 2022 Technical Specifications: *The RRS are then normalized for the AMP HMO/POS population (i.e., across all POs and plans) to a benchmark of 1.0, incorporating partial year enrollment, to generate a member level RRS. Commercial ACO, Medicare Advantage, and Medi-Cal Managed Care risk scores are not normalized.*	
Onpoint Data Submission Guide (DSG)	**ME021, ME024, ME025 – Race and Ethnicity Reporting Requirements**	**Posted 6/15/2023**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** Should reporting race and ethnicity in data fields ME021, ME024, and ME025 in the MY 2023 DSG be limited to Covered California members only? **Response:** No, reporting race and ethnicity is not limited to Covered California members, and these fields should be populated for all members for which the information is available. The threshold applies to Covered California members (ME209 = Y), but these fields are not limited to Covered California members. Please populate these fields for all members where race and/or ethnicity data are available.	
Advancing Care Information Domain	**Controlling High Blood Pressure (ECBP) and Preventive Care and Screening: Screening for Depression and Follow-Up Plan (PREV-12) e-measures**	**Posted 5/16/2023**
Commercial HMO	*Note: This FAQ was originally released in March 2023 and updated in May 2023.* **Question**: CMS made the decision to suppress the ECBP and PREV-12 measures for MY 2022, resulting in the removal of the two e-measures from EHR systems for the measurement year. Are there any plans to adjust the ACI Domain scoring or measure reporting requirements in AMP for MY 2022 due to CMS' suppression of these e-measures? **Response:**	

	May 2023 Update: Pending Program Governance Committee approval, the ACI Domain will be excluded from the MY 2022 Quality Compass Score (QCS) results for AMP Commercial HMO POs. For MY 2022, the maximum QCS a PO may earn is 90 points, based on up to 60 points for its performance on clinical quality measures and up to 30 points for its performance on patient experience measures. *March 2023 Response:* IHA is evaluating the impact of the suppression on benchmarking and the incentive design and will communicate updated guidance on MY 2022 reporting to AMP participants. IHA encourages POs who are able to report the e-measures to submit data as outlined in the MY 2022 DFLs. Please keep in mind that all PO self-reporting in AMP is voluntary and POs may choose which measures to report. Therefore, POs who are unable to report the e-measures can opt to "Not Report" (NR) these measures.	
Onpoint Data Submission Guide (DSG)	**ME203 - Assigned Primary Care Provider NPI**	**Posted 5/16/2023**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** Should reporting the assigned primary care provider NPI number in data field ME203 in the MY 2023 DSG be limited to Covered California members only? **Response:** No, reporting the assigned primary care provider NPI number is not limited to Covered California members, and this field should be populated for all members with an assigned or selected PCP. The updated MY 2023 DSG instructions for data field ME203 are: • Use this field to report the NPI of the member's Primary Care Physician (PCP). This should be populated for all members with a PCP selected or assigned. The threshold applies to Covered CA members (ME209 = Y), but this field is not limited to Covered CA members. It should also be close to 100% populated for HMO product types and a growing number of PPO members.	
Onpoint Data Submission Guide (DSG)	**ME212, TC004, MI007- Accountable Care Organization Identifier (ACO)**	**Posted 5/16/2023**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** How should members belonging to an ACO be identified in the MY 2023 DSG now that ACO IDs are no longer collected for AMP since the ACO product has closed? **Response:** While ACO IDs are no longer being collected, indicating whether a member belongs to an ACO is still required for Atlas reporting. The updated MY 2023 DSG instructions for data fields ME212, TC004, and MI007 are: • Use this field to indicate whether a member belongs to an Accountable Care Organization (ACO). This field is required for Atlas reporting only. If the member belongs to an ACO, please report as "YY." If the member is not assigned to an ACO at all, please report as "ZZ" (Not assigned). ACO IDs are no longer being collected, but all Commercial members must either have "YY" or "ZZ" reported.	
Onpoint Data Submission Guide (DSG)	**PC003- Insurance Type/ Product Code**	**Posted 5/16/2023**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** Which code should be used to report members enrolled in Medicare Advantage Preferred Provider Organizations (PPO) in data field PC003 in the MY 2023 DSG? **Response:** Organizations should use the code "MP" to report members in Medicare Advantage PPO. The updated MY 2023 DSG instructions for field PC003 are:	

- Use this field to report the member's type of insurance or insurance product. To ensure reporting consistency between submitters, all Medicare Advantage plans should use the code "HN" to denote a Health Maintenance Organization (HMO) Medicare Advantage / Medicare Part C. For consistency, please use the same code mapping across files: 837/2000B/SBR/ /09. The only valid codes for this field are:

  EP = Exclusive Provider Organization
  HM = Health Maintenance Organization (HMO) (commercial only)
  HN = Health Maintenance Organization (HMO) Medicare Risk / Medicare Part C
  HS = Special Low-Income Medicare Beneficiary
  IN = Indemnity
  MCF = Medicaid Fee for Service
  MC = Medicaid Managed Care
  MD = Medicare Part D
  PR = Preferred Provider Organization (PPO) (commercial only)
  PS = Point of Service (POS) (commercial only)
  MP = Medicare Advantage Preferred Provider Organization (PPO)

Testing	**Prenatal Immunization Status (PRS-E)**	**Posted 3/29/2023**

Commercial HMO, Medi-Cal Managed Care

Question: When reporting the data type stratifications for the Prenatal Immunization Status (PRS-E) testing measure for AMP MY 2022, there are many instances when an organization may identify members who meet numerator criteria through one data source (e.g., EHR or HIE), but may not identify those same members who meet denominator criteria through the same data sources. This may result in having denominators for the data type stratifications that are lower than the numerators for those same data type stratifications. For example, reporting the PRSE_INFLU indicator may result in the below scenario:

Measure ID	Measure Denominator	Measure Numerator	Rate or Result
PRSEINFLU_EHR	0	7	0.00000
PRSEINFLU_HIE	0	2	0.00000
PRSEINFLU_CM	0	0	0.00000
PRSEINFLU_ADMIN	37	24	0.64864
PRSEINFLU_OVR	37	33	0.89189

How should organizations populate the Health Plan and PO Testing File Layouts for MY 2022 when submitting PRS-E data to FinThrive?

Response: In MY 2022, to report the PRS-E data type stratifications (PRSEINFLU_EHR, PRSEINFLU_HIE, PRSEINFLU_CM, PRSEINFLU_ADMIN, PRSETDAP_EHR, PRSETDAP_HIE, PRSETDAP_CM, PRSETDAP_ADMIN, PRSECOMBO_EHR, PRSECOMBO_HIE, PRSECOMBO_CM, PRSECOMBO_ADMIN), organizations are permitted to report a denominator that has a value less than the numerator. When reporting a PRS-E measure strata with a denominator of 0 and non-zero numerator, report the rate as "0.00000". When reporting a PRS-E measure strata with a non-zero denominator and numerator but the

denominator is less than the numerator, populate the rate as a calculation of the numerator divided by the denominator.

The overall rates (PRSEINFLU_OVR, PRSETDAP_OVR, PRSECOMBO_OVR) must continue to follow the validation rules outlined in the Edit Check column of the Testing Measure ID Table in the Testing File Layouts. The denominator must be the sum of the four data type stratification denominators, and the numerator must be the sum of the four data type stratification numerators. The denominator for the overall rates must be higher than or equal to the numerator for the overall rates. The numerator for the overall rates must be calculated as the total sum of members in the eligible population (the denominator) who meet the numerator criteria; therefore, the overall numerator should be less than or equal to the overall denominator.

The below scenarios use the influenza immunization indicator as an example to indicate which situations would be acceptable when submitting data for the PRS-E measure:

Example #1 – Acceptable. In the below example, the denominator is 0 and the numerator is non-zero for two of the data type stratifications (PRSEINFLU_EHR, PRSEINFLU_HIE). The overall PRS-E influenza (PRSEINFLU_OVR) denominator and numerator are the sum of the four data type stratification (PRSEINFLU_EHR, PRSEINFLU_HIE, PRSEINFLU_CM, PRSEINFLU_ADMIN) denominators and numerators. This will pass validation checks when submitted.

Measure ID	Measure Denominator	Measure Numerator	Rate or Result
PRSEINFLU_EHR	0	7	0.00000
PRSEINFLU_HIE	0	2	0.00000
PRSEINFLU_CM	0	0	0.00000
PRSEINFLU_ADMIN	37	24	0.64864
PRSEINFLU_OVR	37	33	0.89189

Example #2 – Acceptable. In the below example, the denominator is less than the numerator for one of the data type stratifications (PRSEINFLU_EHR) and the denominator is 0 with a non-zero numerator for one of the data type stratifications (PRSEINFLU_HIE). The overall PRS-E influenza (PRSEINFLU_OVR) denominator and numerator are the sum of the four data type stratification (PRSEINFLU_EHR, PRSEINFLU_HIE, PRSEINFLU_CM, PRSEINFLU_ADMIN) denominators and numerators. This will pass validation checks when submitted.

Measure ID	Measure Denominator	Measure Numerator	Rate or Result
PRSEINFLU_EHR	3	7	2.33333
PRSEINFLU_HIE	0	2	0.00000
PRSEINFLU_CM	0	0	0.00000
PRSEINFLU_ADMIN	34	24	0.70588
PRSEINFLU_OVR	37	33	0.89189

Example #3 – NOT Acceptable: In the below example, the denominator is 0 for all four of the data type stratifications (PRSEINFLU_EHR, PRSEINFLU_HIE, PRSEINFLU_CM, PRSEINFLU_ADMIN). As a result, the sum of the overall PRS-E influenza (PRSEINFLU_OVR) denominator is 0, which means it is less than the overall PRS-E influenza numerator. This will **NOT** pass validation checks when submitted.

Note – if a plan or PO did not identify any members who meet the eligible population (criteria specified for the denominator) through ANY data source, then there are no members for which to assess numerator compliance; populate the denominator, numerator and rate as 0 for all stratifications and overall.

Measure ID	Measure Denominator	Measure Numerator	Rate or Result
PRSEINFLU_EHR	0	7	0.00000
PRSEINFLU_HIE	0	2	0.00000
PRSEINFLU_CM	0	0	0.00000
PRSEINFLU_ADMIN	0	24	0.00000
PRSEINFLU_OVR	0	33	#DIV/0!

Example #4– NOT Acceptable: In the below example, the denominator is 0 for three of the data type stratifications (PRSEINFLU_EHR, PRSEINFLU_HIE, PRSEINFLU_CM), the denominator for one data type stratification (PRSEINFLU_ADMIN) is 19 and less than the numerator. Therefore, the sum of the overall PRS-E influenza (PRSEINFLU_OVR) denominator is less than the overall PRS-E influenza numerator. This will **NOT** pass validation checks when submitted.

Note – the overall PRS-E influenza (PRSEINFLU_OVR) numerator must be calculated as the total sum of members in the eligible population (the denominator) who meet the numerator criteria; therefore, the overall numerator should be less than (or equal to) the overall denominator.

Measure ID	Measure Denominator	Measure Numerator	Rate or Result
PRSEINFLU_EHR	0	7	0.00000
PRSEINFLU_HIE	0	2	0.00000
PRSEINFLU_CM	0	0	0.00000
PRSEINFLU_ADMIN	19	24	0.00000
PRSEINFLU_OVR	19	33	1.73684

When reporting the PRS-E measure, please refer to all Guidelines for Measure Reported Using Electronic Clinical Data Systems (ECDS) outlined in the AMP MY 2022 Technical Specifications, and review all AMP FAQs related to ECDS reporting.

Commercial HMO, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** Should patients who have not been diagnosed with diabetes but take diabetes medications for off-label use (e.g., weight loss, heart failure) be excluded from the diabetes measures? **Response:** For the HEDIS diabetes measures, including Hemoglobin A1c Control for Patients with Diabetes (HBD), Blood Pressure Control for Patients with Diabetes (BPD), Eye Exam for Patients with Diabetes (EED), Kidney Health Evaluation for Patients with Diabetes (KED), and Statin Therapy for Patients with Diabetes (SPD) measures, these members remain in the measure. NCQA is working to refine the diabetes denominator related to off-label medication use, and request for feedback on these updates has been added to the annual HEDIS public comment period, which is open until March 13, 2023.	
General	**Guidelines for Measures Reported Using Electronic Clinical Data Systems (ECDS)**	**Posted 2/15/2023**
Commercial HMO, Medicare Advantage, Medi-Cal Managed Care	**Question:** Is non-standard supplemental data permitted for use in reporting ECDS measures? **Response:** Yes, data considered non-standard (and standard) supplemental data can be used for ECDS measures. That said, for ECDS reporting, this information may be categorized as EHR/PHR or HIE/clinical registry data. Manually abstracted data must be audited as nonstandard supplemental data, and meet all criteria as described in General Guideline 31 (MY 2022) or General Guideline 30 (MY 2023) in the AMP Technical Specifications. To determine which data source category should be assigned for reporting purposes, organizations should reference the information provided in Guideline 3: Data Collection Methods of the Guidelines for Measures Reported Using ECDS in the MY 2023 AMP Technical Specifications and consult with their auditor.	
General	**Auditing Data Collected Using Natural Language Processing (NLP)**	**Posted 12/15/2022**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question**: For MY 2022, is a Continuity of Care Document (CCD) acceptable for primary source verification when auditing data collected by NLP? **Response**: No. Data collected using NLP needs to be audited back to the legal health record. CCDs are not considered the legal health record or proof of service and are not a replacement for an electronic health record.	
General	**General Guideline 16: Deceased Members**	**Posted 10/14/2022**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** The “deceased member” exclusion is now required for MY 2023. The last bullet in the Notes section states, “This is a member-level exclusion. For episode-based measures, if one event does not meet numerator criteria, remove all member events/episodes from the measure.” Does this mean that for episode-based measures that if one event meets numerator criteria the member can remain in the measure? **Response:** No. Members who die during the measurement year must be removed from all applicable measures. For episode-based measures, a member who died during the measurement year must be removed for all events (even if they meet numerator criteria for an event).	
Clinical Quality Domain	**Statin Therapy for Patients With Cardiovascular Disease (SPC) and Statin Therapy for Patients With Diabetes (SPD)**	**Posted 10/14/2022**

Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** For MY 2022 and beyond, should we exclude members with a history of allergies or intolerance to statins (including to the PCSK-9 inhibitor) from the SPC and SPD measures? **Response:** The Statin Therapy for Patients With Cardiovascular Disease (SPC) and Statin Therapy for Patients With Diabetes (SPD) measures include an exclusion for members with myalgia, myositis, myopathy or rhabdomyolysis during the measurement year. However, an allergy or history of an intolerance to a statin medication is not considered an exclusion for the measure.	
Clinical Quality Domain	**Multiple Measures (BCS, CCS, CCO, CHL, and OMW)**	**Posted 10/14/2022**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** How should organizations account for transgender and non-binary members in gender-specific measures in AMP for MY 2022 and beyond? **Answer:** For gender-specific measures in AMP, currently the gender specified in enrollment data is used, as this is the gender available in administrative enrollment and claims systems. That said, if other data, such as medical record data, show that the member is biologically a different sex, then they may be removed from the measure. For example, when calculating the Cervical Cancer Screening (CCS) measure, if there is documentation that the member was assigned male at birth (e.g., transgender male to female), then this is evidence that the member does not have a cervix and the member meets the exclusion criteria and may be removed from the measure. In addition, documentation of cervical agenesis or clinical synonyms (e.g., evidence a patient was born without a cervix) may also be used to exclude members. If there is documentation that the member was assigned female at birth (e.g., transgender female to male), there must be documentation of absence of cervix as part of gender reassignment surgery in order to meet exclusion criteria. Male members with documentation that they were assigned female at birth and did not have the cervix removed must remain in the measure because they may still have biological risk of cervical cancer. Codes in the Absence of Cervix Diagnosis Value Set (e.g., ICD-10-CM Diagnosis code Q51.5 [agenesis and aplasia of cervix]) may be used to exclude transgender members from the CCS measure. Please note that if the organization is unable to find the appropriate documentation, these members should remain in the measure. Because AMP is administrative only, medical record data is considered supplemental data. Keep in mind that supplemental data must meet the supplemental data requirements outlined in General Guideline 31 in the AMP MY 2022 Technical Specifications (General Guideline 30 in the AMP MY 2023 Technical Specifications). Supplemental data requires auditor review and approval.	
Appropriate Resource Use Domain	**General Prescribing (GRX)**	**Posted 6/15/2022**
Commercial HMO/POS, Medi-Cal Managed Care	**Question:** Under the denominator section of Step 4 in the GRX measure, it states, "Identify and exclude claims for self-injectable drugs." Which drugs qualify as self-injectable drugs? **Answer:** For the GRX measure, self-injectable drugs are any medications with NDC codes dispensed by an outpatient pharmacy that are described as "injection." If it is prescribed and picked up at an outpatient pharmacy, the assumption is that the patient will be injecting it themselves. Additionally, the generic product name of the drug may	

	say something like "Pen Injector" or "Prefilled syringe" or "Auto-Injector," which may indicate that the drug is set up for self-injection.	
Clinical Domain	**Cervical Cancer Screening and Cervical Cancer Overscreening**	**Posted 2/15/2022**
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** For the CCS and CCO measures, should we exclude transgender women (male to female, never had a cervix)? **Answer:** Administrative data, codes in the Absence of Cervix Diagnosis Value Set (e.g., ICD-10-CM Diagnosis code Q51.5 [agenesis and aplasia of cervix]) may be used to exclude transgender members from the measure. If the medical record documents that the member was born male (e.g., transgender male to female), this is evidence that the member does not have a cervix, meets required exclusion criteria and should be removed from the measure. Medical record documentation of cervical agenesis or clinical synonyms (e.g., evidence a patient was born without a cervix) can also be used to exclude these members.	
General	**Medi-Cal Managed Care Continuous Enrollment and Member Attribution**	**Posted 12/15/2021**
Medi-Cal Managed Care	**Question:** How are continuous enrollment and member attribution to provider organizations (POs) determined differently for Onpoint-generated MY 2020 results using health plan data in the AMP Medi-Cal Managed Care program than in the AMP Commercial HMO program? **Answer:** The AMP Medi-Cal Managed Care program does not apply continuous enrollment at the plan-PO level for Onpoint-generated quality measure results using health plan data, as the AMP HMO program does. For Onpoint-generated AMP Medi-Cal Managed Care results, a member must be enrolled in a health plan and a PO for at least 1 month before becoming eligible for a measure. The member must also be continuously enrolled in the health plan for the benefit specified for each measure (e.g., medical and/or pharmacy), accounting for any allowable gaps, to be considered continuously enrolled. Onpoint then uses a "Frequency and Last Record Hierarchy" approach to determine member attribution for AMP Medi-Cal Managed Care quality results. POs are ranked based on length of enrollment for a member for the measurement year and then attributed to the PO they are affiliated with for the longest time. If a member belongs to more than one PO for equal time, a tiebreaker is determined using the most recent PO the member was associated with. **To note, because of differences in data capture and approach, health plan results generated by Onpoint and self-reporting Medi-Cal Managed Care results may differ.** Member attribution for Onpoint-generated quality results in AMP Medi-Cal Managed Care have not changed for MY 2020 and have been applied as described above since the program's inception.	
General	**General Guideline 17: Deceased Members**	**Posted 11/15/2021**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs. This was originally released in November 2021 and updated in December 2021.* **Question:** How should we apply the "deceased members" exclusion in *General Guideline 17: Deceased Members* for episode-based measures?	

	Answer: The guideline for deceased members (General Guideline 17) is a member-level exclusion. For episode-based measures, if one event does not meet numerator criteria, and the organization chooses to use this optional exclusion, remove all member events/episodes from the measure. This FAQ applies to MY 2022 and beyond.	
General	**General Guideline 32: Race and Ethnicity Stratification**	**Posted 10/15/2021**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** May supplemental data be used for race and ethnicity stratifications? **Answer:** Yes. For MY 2022 and beyond, supplemental data may be used to identify race and ethnicity when stratifying the eligible population.	
General	**PCS Questions**	**Posted 9/15/2021**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** Do answers from the Policy Clarification Support system have an expiration date? **Answer:** We recommend that organizations not use PCS responses that are over 3 years old. If a question relates directly to a measure specification or a general guideline that was revised from a previous measurement year, we recommend resubmitting the question.	
Appropriate Resource Use	**Acute Hospital Utilization and Emergency Department Utilization**	**Posted 9/15/2021**
Commercial HMO/POS	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** May covariance values be rounded before using them in the variance calculation? **Answer:** No. Do not round covariance values for use in variance calculations. Member-level PPD and PUCD should be unrounded in covariance and variance calculations, although truncation to 10 decimal points is applied, per the previous step. NCQA intends to evaluate truncation and rounding logic throughout intermediate calculations to ensure consistency and reduce potential bias in a future measurement year.	
Appropriate Resource Use	**Acute Hospital Utilization and Emergency Department Utilization**	**Posted 9/15/2021**
Commercial HMO/POS	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** When should rounding occur for variance calculations? **Answer:** The variance should not be rounded until the final step in the calculation. The final variance calculation for reporting should be rounded to four decimal places using the .5 rule. For example, the PPD and PUCD values are truncated to 10 decimal places, multiplied together at the member level and summed across members for the total. Round the total sum to four decimal places.	
General	**General Guideline 13: Members with Dual Enrollment**	**Posted 1/15/2021**
Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.*	

	Question: What type of Medicare enrollment counts when assessing members with dual Medi-Cal Managed Care and Medicare Advantage enrollment? **Answer**: General Guideline 13 includes language about Medicare contracts required to report. These are meant to indicate Medicare Advantage. Having only Medicare Part D does not qualify as coverage for dual enrollment.	
General	**General Guideline 13: Members with Dual Enrollment**	**Posted 1/15/2021**
Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: When a member has dual Medi-Cal Managed Care/Medicare Advantage enrollment, how long must the member be enrolled in Medicare Advantage to be removed from the Medi-Cal Managed Care product line? **Answer**: There is no minimum enrollment requirement. Per General Guideline 13, members must meet the measure's continuous enrollment requirements and be considered dually enrolled based on continuous enrollment criteria or the service date. Organizations must follow General Guideline 13 with regard to assessing coverage and should review enough data to meet the measure specification requirement.	
Clinical Quality	**Controlling High Blood Pressure**	**Posted 12/15/2020**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: Is the use of average blood pressure readings allowed? **Answer**: Yes, but only average readings that include separate values for systolic and diastolic blood pressure may be used for reporting.	
Appropriate Resource Use	**Emergency Department Utilization**	**Posted 12/15/2020**
Commercial HMO/POS	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: In the EDU measure, step 1 for the Calculation of Observed Events says to exclude ED visits that result in an inpatient stay or an observation stay. Should denied claims be used when looking for both an inpatient stay and an observation stay in this case? **Answer**: Yes. When confirming that an ED visit does not result in an inpatient stay or an observation stay, all inpatient and observation stays must be considered, regardless of payment status (paid, suspended, pending, denied). Measure Certification will test this scenario to ensure all inpatient and observation stays are considered, regardless of payment status. For example, if an ED visit is paid but an inpatient stay is denied, the ED visit resulted in an inpatient stay and is not included in the Emergency Department Utilization measure when identifying observed ED visits. Refer to Guideline 1 under "Guidelines for HEDIS Risk Adjusted Utilization Measures" in the AMP Technical Specifications.	
Clinical Quality	**Child and Adolescent Well-Care Visits**	**Posted 9/15/2020**
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: When reporting the WCV measure using supplemental data, may organizations combine documentation from multiple visits to meet criteria?	

	Answer: No, combining documentation from multiple visits is not allowed. Medical record data must come from a single date of service and must indicate that a well-care visit occurred that was equivalent to the definition of one of the codes in the Well-Care Value Set.	
Clinical Quality	**Child and Adolescent Well-Care Visits**	**Posted 9/15/2020**
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: For the WCV measure, what are the required data elements for supplemental data? **Answer**: Services and documentation in the supplemental data (e.g., medical record) must be clinically synonymous with the codes in the measure's administrative specification. The organization determines this, and it is reviewed by the auditor. Supplemental data must adhere to requirements in *General Guideline 31* of the AMP Technical Specifications.	
Clinical Quality	**Controlling High Blood Pressure**	**Posted 9/15/2020**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: Do BP readings taken by the member need to meet the member-reported requirements included in *General Guideline 40*? **Answer**: No. BPs taken by the member do not need to meet requirements for member-reported data described in *General Guideline 40* (collected by a PCP or other specialist while taking the patient's history). If the BP result is documented in the member's medical record, it may be used to assess numerator criteria if the BP does not meet any exclusion criteria listed in the measure specification.	
Clinical Quality	**Childhood Immunization Status**	**Posted 9/15/2020**
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: Does the live attenuated influenza vaccine (LAIV) vaccination have to be given on the child's second birthday? **Answer**: Yes. The LAIV vaccination only counts if it is administered on the child's second birthday. The minimum age for LAIV is 2 years, so vaccines given before that age do not meet criteria. You can view the recommendation guidelines on the CDC website (https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf).	
Clinical Quality	**Palliative Care Exclusion (Cross-cutting)**	**Posted 9/15/2020**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: May supplemental data be used to identify members for the Palliative Care exclusion? **Answer**: Yes. Although the required palliative care exclusion is intended to be identified using administrative data, supplemental data may also be used. If organizations use supplemental data to remove members in palliative care, they must follow the supplemental data guidelines (*General Guideline 31*). Use of supplemental data are subject to auditor approval.	
Clinical Quality	**Childhood Immunization Status/Immunizations for Adolescents**	**Posted 1/15/2020**
Commercial HMO/POS, Medi-Cal Managed Care	**Question:** Beginning in December 2019, the California Immunization Registry (CAIR) updated their data sharing process, giving patients the choice not to disclose their immunization records (http://cairweb.org/docs/Revised_HEDIS_12112019.pdf). How will IHA handle the CIS and IMA performance rates, if providers are unable to use data from CAIR records for reporting?	

	Answer: IHA is aware of the policy change and will monitor the MY2019 data to determine any effects of the CAIR policy change on reporting, and identify measures for addressing it, if necessary.	
Clinical Quality	**Cervical Cancer Overscreening**	**Posted 1/15/2020**
Commercial HMO/POS, Medi-Cal Managed Care	**Question:** There is a note in the measure specification which says "If two or more claims/encounters with qualifying numerator codes for cervical cytology occur within 14 days of each other, count only the first one. Refer to General Guideline 35." Does this general guideline also apply to hrHPV tests? **Answer:** The guidance applies to both cervical cytology and high-risk HPV tests. If two or more claims for hrHPV testing occur within 14 days of each other, count only the first one.	
General	**General Guideline 50: Mapping Proprietary or Other Codes**	**Posted 12/16/2019**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: Organizations may map NDC or RxNorm codes based on generic name (or brand name), strength/dose and route. What information is used to map "dose" or "route"? **Answer**: For mapping purposes, the organization must demonstrate that the medication being mapped is the same as a medication listed in the Medication List Directory (MLD). For example, the route for "benralizumab" is listed as "injection" in the Asthma Controller Medications table. The MLD lists generic products for benralizumab, including "1 ML benralizumab 30 MG/ML Prefilled Syringe" and "benralizumab 30 MG/ML Prefilled Syringe," where the Route is listed as "injection." Therefore, it would be appropriate to map a code with the generic name "benralizumab" and strength "30 MG/ML and dose form or route of either "syringe" or "prefilled syringe" or "injection." Another example is fluticasone, which is listed as "inhalation" in the Asthma Controller Medications table. The MLD (Generic Product Name) identifies appropriate dose/forms as "metered dose inhaler" or "dry powder inhaler," and lists the route as "inhalation." Therefore, it would be appropriate to map codes for fluticasone if the strength/dose matches one in the MLD and if the dose form or route is "inhaler" or "metered dose inhaler" or "powder inhaler" or "inhalation." It would not be appropriate to map codes for fluticasone with dose form or route of "nasal spray."	
Clinical Quality	**The "Route" column in the Asthma Medication Ratio measure**	**Posted 12/16/2019**
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: In the Asthma Controller Medications table and the Asthma Reliever Medications table (in the AMR measure specifications), what is the "Route" column used for? **Answer**: Use the "Route" information from the tables to apply the "Definitions" for calculating an "inhaler dispensing event" and an "injection or intravenous dispensing event." For routes listed as "subcutaneous" or "intravenous," use the "injection or intravenous dispensing event" definition. *Note: In the Medication List Directory (MLD), the "Route" column lists "subcutaneous" and "intravenous" as "injection."*	
General	**Codes Found in Medical Records**	**Posted 10/23/2019**

Note: This FAQ was released for HEDIS and applies to the AMP programs.

Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care

Question: For General Guideline 31: Supplemental Data, may codes found in the medical record be used as proof of service even if there is no additional documentation of the service provided?

Answer: No. Codes alone (without additional documentation of the service provided) do not meet criteria for proof of service. If a provider performs a service, it is expected that additional documentation exists in the medical record or in the primary source document. Auditors must validate, through primary source verification, all elements required by the administrative measure specification.