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

June 2024

Clinical Quality Domain	Colorectal Cancer Screening (COL-E)	Posted 6/15/2024
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** In the Allocation section for the COL-E measure in the Final MY 2024 AMP Technical Specifications, the second bullet under "For self-reporting POs" states, "*For Medi-Cal Managed Care reporting:* The member was enrolled in the health plan and in the PO (parent level) with a medical benefit during the measurement period." Is this correct? **Response:** The second bullet should align with the first bullet, and self-reporting POs should only assess continuous enrollment in the PO for Medi-Cal Managed Care reporting in MY2024. The second bullet under "For self-reporting POs" in the Allocation section of the COL-E specification should state: *"For Medi-Cal Managed Care reporting:* The member was enrolled in the PO (parent level) with a medical benefit during the measurement period." This was a transcription error and will be updated in the Draft MY2025 AMP Technical Specifications, scheduled for release in October 2024.	
Clinical Quality Domain	**Asthma Medication Ratio (AMR)**	**Posted 6/15/2024**
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs* **Question:** For MY 2024 reporting, can RxNorm codes be used when identifying the required exclusion for members who had no asthma controller or reliever medications dispensed during the measurement year? **Response:** No. Although the Asthma Controller and Reliever Medication List includes RxNorm codes, they should not be used to identify dispensing events for this required exclusion. A member who has a dispensing event using only RXNorm codes qualifies as a required exclusion. Only use pharmacy data (NDC codes) when assessing asthma controller or reliever medication dispensing events for this required exclusion. Because a dispensing event is required to calculate the numerator, members who had no dispensing events should be removed.	
General	**Direct Reference Codes**	**Posted 5/15/2024**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** Why are some codes included in the measure specification and not included in a value set? **Response:** When only a single code exists for a service or condition, it is included directly in the measure specification, and referred to as a Direct Reference Code	

	(DRC). It is a best practice to not create value sets that include only a single code; some code systems prohibit this because it results in assigning another code (an OID) to a concept that already has a code. DRCs are listed in the measure specifications and in a Direct Reference Codes spreadsheet in the value set directory. For AMP MY 2024, a number of single code value sets were converted to DRCs. The Summary of Changes - Value Sets spreadsheet indicates the value set was deleted. The Summary of Changes - Codes spreadsheet indicates the code was added as a DRC (filter Column A on "Direct Reference Code").	
Clinical Quality Domain	**eGFR and uACR Timing for Kidney Health Evaluation for Patients With Diabetes (KED)**	**Posted 5/15/2024**
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 2024, when does the "with service dates four days or less apart" specification apply? **Response:** The numerator criterion is an eGFR and a uACR any time during the measurement year. These separate tests may occur on different dates. The 4-day proximity language is specific to a reporting option for uACR, where a quantitative urine albumin test and a urine creatinine test may be billed separately. In practice, the quantitative urine albumin and urine creatinine tests are performed on the same date, from the same urine sample, to produce a single ratio. The 4-day proximity language intends to account only for potential billing lags between the separate quantitative urine albumin and urine creatinine administrative codes that indicate a single uACR evaluation; it is not intended for separate samples from different dates.	
General	**Onpoint Data Submission Guide (DSG)**	**Posted 4/15/2024**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** How should my organization approach the submission of HbA1c results associated with LOINC codes 17855-8 and 96595-4 and SNOMED codes? The MY 2023 AMP Value Set Directory includes LOINC codes 17855-8 and 96595-4 and SNOMED codes as a possible source for HbA1c result reporting. However, the Data Submission Guide (DSG) Lab Results file specifications that are meant to collect HbA1c results do not have LOINC codes 17855-8 and 96595-4 listed as valid values and do not have a field to capture SNOMED codes. **Response:** The exclusion of LOINC codes 17855-8 and 96595-4 and SNOMED codes in the DSG was an oversight when updating the previous version of the DSG. This issue has been addressed with updates to the MY 2024 DSG that replaces the Lab Results file specifications with the Supplemental Data file specifications. The Supplemental Data file specifications contain a field to capture SNOMED codes, and the updated references capture all relevant LOINC codes (in addition to other relevant code sets such as ICD, CPT, Revenue Code, etc.). However, this adjustment does not address historical submissions prior to MY 2024. Because IHA remains committed to capturing and publishing the most accurate, high-quality data possible, IHA will work with concerned health plans to capture any relevant missing historical HbA1c results prior to MY 2024. If you would like more information, please contact your AMP Client Success Manager and/or email amp@iha.org.	
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 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,	*Note: This FAQ was released for HEDIS and applies to the AMP programs.*	

Medicare Advantage, Medi-Cal Managed Care	**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:** 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	
Digital Measure Packages	**ECDS Measures (BCS-E, COL-E, DSF-E, PRS-E)**	**Posted 10/13/2023**
Commercial HMO/POS, Medicare Advantage,	*Note: This FAQ was released for HEDIS and applies to the AMP programs.*	

Medi-Cal Managed Care	**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.	
Clinical Quality Domain	**Cervical Cancer Screening (CCS)**	**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 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)	**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.	
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.	
Clinical Quality Domain	**Statin Therapy for Patients With Cardiovascular Disease (SPC)**	**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 measure? **Response:** The Statin Therapy for Patients With Cardiovascular Disease (SPC) measure includes 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, 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.	
Clinical Domain	**Cervical Cancer Screening**	**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 measure, 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 32: Race and Ethnicity Stratification**	**Posted 10/15/2021**
Commercial HMO/POS,	*Note: This FAQ was released for HEDIS and applies to the AMP programs.*	

Medicare Advantage, Medi-Cal Managed Care	**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.	
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.	