Integrated Healthcare ASSOCIATION

Frequently Asked Questions
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October 2026

Note: For questions related to health plan submissions to Cozeva, please refer to the Frequently Asked Questions for Health Plan Submissions to Cozeva.

Clinical Quality Domain	Cervical Cancer Screening (CCS-E)	Posted 10/15/2026
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** How can organizations identify vaginal self-swab HPV samples for the CCS-E measure? **Response:** The CCS-E measure allows at-home, self-collected HPV vaginal samples that are sent to a laboratory or provider's office for analysis (see General Guideline: Member-Collected Samples). Organizations can identify qualifying screenings through multiple approved data sources, including claims, laboratory data, electronic clinical data and medical records. The absence of a specific code does not exclude identification of a qualifying screening if the organization can demonstrate numerator compliance using an approved data source that meets the requirements of the measure. When using supplemental data (e.g., laboratory data, electronic clinical data or medical record documentation) to assess the numerator (i.e., the provider did not bill one of the codes in the measure), the documentation must meet the requirements outlined in General Guideline: Supplemental Data. NCQA does not approve code mapping, and the auditor will determine whether the data meet the intent of the measure. If a laboratory bills for the test using any of the CPT codes in the High Risk HPV Lab Test Value Set, then this meets numerator criteria. The CPT codes are not specific to sample type (vaginal versus cervical) therefore billing is based on the specific assay and types being detected by the laboratory.	

Clinical Quality Domain	**Cervical Cancer Screening (CCS-E)**	**Posted 10/15/2026**
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** Are there LOINC codes available to capture Vaginal self-swab HPV samples for the CCS-E measure in MY 2026? **Response**: No, because new LOINC codes were released after publication of MY 2026 Final Technical Specifications, organizations can use supplemental data to meet the numerator requirements. The documentation must meet the requirements outlined in General Guideline: Supplemental Data. NCQA does not approve code mapping, and the auditor will determine whether the data meet the intent of the measure.	

	New codes for self-collected specimens were included in LOINC's recent release and additional pre-release codes are currently published on the LOINC website (and will be included in the next LOINC release). NCQA will review and include appropriate codes in the MY 2027 Final Technical Specifications release, scheduled for June 1, 2027.	
Clinical Quality Domain	**Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)**	**Posted 10/15/2026**
Commercial HMO/POS, Medi-Cal Managed Care	**Question:** How is the COPD diagnosis stratification reported for the AAF-E measure? **Response:** Beginning with MY 2026, the AMP program includes a modification to the HEDIS measure specification for reporting the AAF-E measure. Organizations should report the COPD diagnosis stratification separately from the age stratifications. The COPD diagnosis stratification is not required to be reported within each age stratification. This modification from the HEDIS measure specification is noted in the MY2027 Draft Technical Specifications and will also be reflected in the MY2026 Data File Layouts.	
General	**Policy Clarification Support (PCS) system**	**Posted 9/15/2026**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** Do answers from the Policy Clarification Support system have an expiration date? **Response:** Organizations may not use PCS responses that are over 3 years old. Questions that relate directly to a measure specification or general guideline that was revised from a previous measurement year should be resubmitted rather than using the previous answer in PCS.	
Clinical Quality Domain	**Depression Screening and Follow-up for Adolescents and Adults (DSF-E)**	**Posted 9/15/2026**
Commercial HMO/POS, Medi-Cal Managed Care	**Question:** If a member has multiple positive depression screenings during the measurement period, which screening is used to assess follow-up for the Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) measure? **Response:** For DSF-E, use the first positive depression screening between January 1 and December 1 of the measurement period to assess Follow-Up on Positive Screen. If a member has multiple positive depression screenings during the measurement period, only the first will be assessed for a follow-up.	
Data Quality Domain	**Encounter Rate by Service Type (ENRST) Measure**	**Posted 7/15/2026**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** The AMP MY 2026 Technical Specifications clarify that ENRST indicators must be reported separately by transaction type (claims and encounters). How should organizations determine whether a transaction is classified as a claim or an encounter? Will the MY 2026 Measure Certification Handbook Appendix F layouts and fields be updated to report claims and encounter counts separately for each service type? **Response:** IHA and NCQA are not prescriptive on workflows for identifying encounters or claims for the ENRST measure. Organizations should refer to the guidelines and definitions included in the MY 2026 AMP Technical Specifications to determine if a service included in the numerator value sets refers to a claim or an encounter. The methodology used must be consistent across all rates for this measure. The MY 2026 measure certification decks will continue to only test total number of encounters for ENRST and will not test for the stratification by claims and encounters. It is up to organizations to determine stratified claims and encounters when reporting for AMP.	
Clinical Quality Domain	**Colorectal Cancer Screening (COL-E)**	**Posted 7/15/2026**

Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** Are sRNA stool or blood tests included as an acceptable form of screening for the Colorectal Cancer Screening (COL-E) measure? **Response:** No. Per the measure steward, NCQA, at this time, these tests are not included in the COL-E measure or its value sets and we cannot predict if or when sRNA tests will be added. NCQA relies on a broad body of scientific evidence and guidance from multiple independent clinical guideline bodies when developing and updating quality measures. These include, but are not limited to, recommendations from the U.S. Preventive Services Task Force (USPSTF), as well as other national organizations. NCQA monitors emerging screening concepts and reviews evidence as it becomes available through its established measure development processes. Because of this, while some tests may receive FDA authorization and are covered under certain CMS policies, they are not automatically included in our measures. NCQA will continue to review the guidelines and scientific literature, and communicate changes if they are made.	
Clinical Quality Domain	**Glycemic Status Assessment for Patients With Diabetes (GSD)**	**Posted 7/15/2026**
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 portable point-of-care HbA1c devices approved for the GSD measure and are HbA1c results obtained from these devices acceptable for AMP reporting? **Response:** HbA1c results obtained from portable point-of-care devices are acceptable when the test is performed by clinical staff, regardless of whether the test is conducted at home or in a provider office. Member-collected samples are also acceptable if sent to a laboratory or provider's office for analysis and result calculation. Self-administered tests reported by the member do not meet criteria (General Guideline: Member-Collected Samples).	
Clinical Quality Domain	**Prenatal and Postpartum Care (PPC)**	**Posted 7/15/2026**
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** With the maternity care service coding changes taking effect in 2027, does AMP plan to update its maternity-related measures to accommodate these changes? **Response:** Yes, changes to the Prenatal and Postpartum Care measure will be included in the AMP MY Draft 2027 Technical Specifications (scheduled for release on 10-12-2026) to align with HEDIS MY 2027. Consistent with the planned changes for maternity care billing, evaluation and management codes in combination with a TH modifier will meet criteria for prenatal and postpartum care. Codes no longer used for maternity care services will not be removed from the measure until the lookback period has passed. We anticipate additional codes may be added to the measure in the Final AMP MY 2027 Technical Specifications release after CPT releases the full code set publication in the fall of 2026.	
General	**AMP MY2026 Final Technical Specifications**	**Posted 4/15/2026**
Commercial HMO/POS, Medicare Advantage,	**Question**: What major updates will be included in the AMP MY 2026 Final Technical Specifications?	

Medi-Cal Managed Care	**Response**: The AMP MY 2026 Final Technical Specifications, scheduled for release on June 1, 2026, will include the following key updates: • The Statin Use in Persons with Diabetes (SUPD) measure will be reported via the FinThrive health plan clinical submission pipeline for AMP Medicare Advantage beginning in MY 2026. • The Statin Therapy for Patients with Cardiovascular Disease (SPC-E) measure will be removed from the MY 2026 AMP measure set. • The Combination 3 and Combination 7 rates will be included in the Childhood Immunization Status (CIS-E) measure for MY2026 reporting in addition to Combination 10, in alignment with the HEDIS specification. These new rates are "Information Only" and IHA will continue to use Combination 10 results for MY 2026 AMP incentives, awards, and public reporting. • The full Primary Care Spending (PCS) measure specification, adapted from the Office of Health Care Affordability (OHCA) Definition and Methodology, will be included in the AMP MY 2026 Final Technical Specifications. These updates are also reflected in the AMP MY 2026 Measure Set, posted on IHA's website.	
Clinical Quality Domain	**Eye Exam for Patients with Diabetes (EED)**	**Posted 3/13/2026**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question**: Is dilation necessary for a retinal eye exam to meet criteria for the EED measure for AMP MY 2025 and AMP MY 2026 reporting? **Response**: No, dilation is not necessary to satisfy the EED measure. Documentation must be clear that the patient had an eye exam performed by an eye care professional (i.e., optometrist or ophthalmologist), and that retinopathy was not present. Keep in mind that the documentation must also include a date specific enough to indicate that the eye exam occurred during the measurement year. Note that for AMP reporting, medical record data is considered supplemental data and must meet the criteria listed in the supplemental data General Guideline. The information/documentation in the supplemental data source must be clinically synonymous with the codes in the measure's numerator value sets.	
General	**Use of C-CDA documents from a Health Information Exchange**	**Posted 1/15/2026**
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 2026, can C-CDA documentation, such as a Continuity of Care Documents (CCD), from a Health Information Exchange (HIE) be used as proof-of-service? **Response:** No. C-CDA documents cannot be used for proof-of-service as the documents are electronically generated and not the same as the medical record documented in the primary source system where care was originally recorded (e.g. electronic medical record). This includes C-CDA documents received from HIEs. HIEs support the exchange of clinical information, an important function for the delivery of care. Organizations are encouraged to use electronic files received from an HIE, such as an electronic C-CDA or FHIR documents (e.g., C-CDA XML, FHIR JSON) as a supplemental data source.	
Clinical Quality Domain	**Eye Exam for Patients with Diabetes (EED)**	**Posted 12/15/2025**
Commercial HMO/POS, Medicare Advantage,	**Question:** Is a patient with bilateral blindness or bilateral ocular prosthetics excluded from the EED measure?	

Medi-Cal Managed Care	**Response:** For AMP reporting, members with bilateral eye enucleation any time during the member's history through the last day of the measurement period meet required exclusion criteria for the EED measure. The measure steward, NCQA, expects these codes to be present for anyone with bilateral ocular prosthetics. Members who are blind are not excluded from the EED measure because the benefit of retinal exams depends on underlying pathology, not vision loss. The number of members who are blind is expected to be low and evenly distributed across health plans and therefore is unlikely to materially impact measure rates or hinder comparisons between organizations.	
General	**Gender and Risk Adjusted Utilization Measures (PCR, EDU, AHU)**	**Posted 12/15/2025**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** For AMP MY 2026, administrative gender codes for male and female were added to the initial population of the risk adjusted utilization measures. Are unknown or nonbinary genders reported in these measures? Is this a new criterion? **Response:** Members with an unknown or nonbinary gender do not qualify for the risk adjusted utilization measures (PCR, EDU, AHU) because these measures require a gender to assign age/gender weights. These members should be removed from the measures. This is not a change; measure models have always included male and female weights. The use of the administrative gender codes for MY 2026 clarify which members are included in the initial population.	
General	**Direct Transfers and Observation Stays (PCR, AHU, AAF-E)**	**Posted 12/15/2025**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** For measures that assess for direct transfers between acute inpatient facilities and observation stays in MY 2025 and MY 2026, does each inpatient hospital stay need to be both acute and observation to be eligible for direct transfer? **Response:** No. Each inpatient hospital stay does not need to be both acute and observation for direct transfer. When assessing direct transfer, include those with acute inpatient to acute inpatient, observation to observation, acute inpatient to observation and observation to acute inpatient.	
Clinical Quality Domain	**Depression Screening and Follow-up for Adolescents and Adults (DSF-E)**	**Posted 11/14/2025**
Commercial HMO/POS, Medi-Cal Managed Care	**Question:** Is a telephone encounter acceptable to capture a depression screening for the DSF-E measure? **Response:** For the Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) measure, the screening does not need to occur during a face-to-face encounter for MY 2025 and MY 2026 reporting. It may be completed over the telephone or through a web-based portal (for initial or follow up screenings). The screening must be a standard assessment instrument normalized and validated for the appropriate patient population, which are listed in the measure.	
Clinical Quality Domain	**Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)**	**Posted 11/14/2025**
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** Is the PHQ-9M (Patient Health Questionnaire Modified for Teens) the same as the PHQ-A (Patient Health Questionnaire Modified for Adolescents)?	

	Response: No. The PHQ-A is a different tool than the PHQ-9M, and is not included in Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) for MY 2025 and MY 2026. Organizations may map appropriate screenings and results from any pre-specified tool to the LOINC codes in the specification. If the core 9 questions in the PHQ-A are the same as those in the PHQ-9M, the same LOINC may be mapped. Auditors review all code mapping as part of the annual review.	
General	**Requirements for Pharmacy Data in Supplemental Sources**	**Posted 11/14/2025**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** What data elements must be present in a supplemental source that contains pharmacy data? **Response:** The following data elements must be present for pharmacy data: • Generic name (or brand name). • Strength/dose. • Route. • Dispensed or shipped date (i.e., the date when the medication was dispensed or shipped). Medical record documentation that an individual was prescribed a medication, or that lists current/active medications, does not meet criteria. The dispensed date is required. For mailed prescriptions, the shipped date is considered the dispensed date.	
General	**Proof of Service Requirements for Supplemental Data**	**Posted 11/14/2025**
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 acceptable proof of service documentation for data in a supplemental source? **Response**: Proof of service is the primary source documentation for a service or a result (not a secondary representation of the information) and should originate from the source system where it was first documented. Acceptable proof of service: • A copy of the information from the member's chart from the service provider or PCP. • A copy of the clinical report or clinical summary from the visit for service, such as lab or radiology reports. • A screen shot of the EHR records or state- or county-sponsored immunization registry records. Proof of service is primary source documentation, not a secondary representation of that information. The following provide examples that are not considered proof of service: • C-CDA or FHIR files are electronically generated, and are not proof of service. • Attestation forms are not the original source of documentation for an encounter, and are not proof of a service or result.	
General	**Use of Provider Attestations for AMP**	**Posted 11/14/2025**
Commercial HMO/POS, Medicare Advantage,	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** Does AMP allow provider attestations or portal data?	

Medi-Cal Managed Care	**Response:** Provider attestations or portal data are allowed in specific scenarios and when all requirements are met. Organizations may obtain information from providers on services that were rendered via attestation forms or provider portal interfaces. These are considered supplemental sources, and must be substantiated with proof-of-service documentation (e.g., original medical record). In particular, organizations may not use provider attestations or data entered in an electronic platform as evidence that a service was rendered (i.e., as proof of service). This includes attestation forms filed in the member's record, which are not primary sources for the information.	
General	**Use of Member-Reported Data for AMP**	**Posted 11/14/2025**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs* **Question:** Does AMP allow information reported directly from members? **Response:** Member-reported data are allowed in specific scenarios, and when all requirements are met. **Organizations may not call members to collect AMP data.** The expectation is that member-reported data are generated during an encounter where the member receives care. Some AMP data are reported by members; for example, when standardized assessment tools are used (e.g., PHQ-2), or when documenting language preference, race and ethnicity. Services and biometric values reported by members are permitted if they adhere to the following guidelines in the AMP Technical Specifications: • ***Member-Reported Services and Biometric Values*** **general guideline.** Member-reported services may be used if collected by a PCP or specialist (if the specialist is providing a primary care service related to the condition being assessed, in the course of taking a member's history), and if the information is in the member's health record. • ***Supplemental Data*** **general guideline.** Information on services reported by members often reside in non-standard supplemental sources. The supplemental data general guideline states that there must be evidence of provider accountability for the information documented. Documentation of member-reported services must be complete (date, place of service, procedure, prescription, test result or finding, practitioner type).	
General	**Policy Clarification Support System (PCS) Questions**	**Posted 9/15/2025**
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? **Response:** Yes. Organizations may not use PCS responses that are over 3 years old. If your question relates directly to a measure specification or general guideline that was revised from a previous measurement year, submit the question rather than using the answer in PCS.	
Data Quality Domain	**Encounter Rate by Service Type (ENRST) Measure**	**Posted 8/15/2025**

Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** How should the required exclusion for deduplication be handled for the claims and encounters stratifications and overall rates for ENRST for MY 2025 AMP reporting and beyond? **Answer:** For MY 2025 AMP reporting and beyond, the "total" or “overall” rate for each ENRST indicator is calculated as a deduplicated value which could be less than the sum of the claims and encounters stratifications; therefore, a member who has both a claim and an encounter on the same date of service by the provider will contribute once to the claims stratification, once to the encounters stratification, and once to the overall rate. For example, if a member has 1 claim and 1 encounter for the same Rate 1 outpatient service with the same provider on the same date, the member's reported count should be 1 count of claim, 1 count of encounter, and 1 count toward the overall. If the member has 2 encounters and 2 claims on the same date of service by the same provider, then deduplication will also apply at the stratification level - the member contributes 1 count of claim, 1 count of encounter, and 1 count toward the overall total. Please note that deduplication applies to all ENRST rates EXCEPT rates 4b and 5b (these rates are not subject to deduplication or stratification by claim and encounter).	
Data Quality Domain	**Encounter Rate by Service Type (ENRST) Measure**	**Posted 8/15/2025**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** Are the Overall Professional Encounter rate, the Overall Institutional Encounter Rate, and Overall Rate each stratified by claims and encounters? **Answer:** Yes, the Overall Professional Encounter rate, the Overall Institutional Encounter Rate, and Overall Rates are stratified by claims and encounters. Plans will therefore report (1) a claims stratification, (2) and encounter stratification, and (3) an overall that is deduplicated by claim/encounter.	
Clinical Quality Domain	**Cervical Cancer Screening (CCS-E)**	**Posted 5/15/2025**
Commercial HMO/POS, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs* **Question:** For the CCS-E measure in MY 2025, does an HPV or Pap test that has a sample source of vaginal meet criteria for the numerator? **Response:** Yes. If the HPV or Pap test sample source is vaginal, and can be billed to an appropriate code in the value sets, it may be used to meet criteria.	
Data Quality Domain	**Encounter Rate by Service Type (ENRST) Measure – Rate 7 (MY 2024)**	**Posted 4/15/2025**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** In MY 2024, was the ED POS Value Set intentionally removed from being used in conjunction with ED Procedure Code Value Set in the Encounter Rate 7: ED Visits indicator? **Response:** The ED POS Value Set (previously included in the ENRST measure specification) was retired and replaced with a Direct Reference Code (DRC) – POS code 23. When reporting Encounter Rate 7: ED Visits, plans are to identify ED visits using the ED Procedure Code Value Set in conjunction with POS code 23. See guidance in the below screenshot.	

Encounter Rate 7: **ED Visits**	
Denominator	Member years (submitted by health plans as member months, and then calculated and reported as member years).
Numerator	Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following: • An ED visit (ED Value Set). • A procedure code (ED Procedure Code Value Set) ***with*** an ED place of service code (POS code 23). Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set).

Clinical Quality Domain	**Statin Use in Persons with Diabetes (SUPD)**	**Posted 1/15/25**
Medicare Advantage	**Question:** Are we able to use supplemental data sources to identify dispensing events for reporting the Statin Use in Persons with Diabetes (SUPD) measure? **Response:** No, the use of supplemental data sources is NOT allowed for SUPD measure reporting. The only data sources specified within the SUPD measure are medical claims and prescription pharmacy claims; supplemental data outside of these sources are not permitted to be used for measure calculation.	

General Guidelines	**Member Reported Services**	**Posted 11/15/24**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs* **Question:** What guidance in the AMP Technical Specifications can be referenced to determine if member-reported services data can be used? **Response**: The MY2024 Final Technical Specification and beyond provides guidance in several places: · **General Guideline: Member-Reported Services and Biometric Values.** This general guideline states that member-reported services may be used only if collected by a primary care practitioner or specialist (if the specialist is providing a primary care service related to the condition being assessed, while taking a member's history), and if the information is included in the member's health record. · **General Guideline: Supplemental Data.** Information on services reported by members often reside in non-standard supplemental sources. The supplemental data general guideline states that there must be evidence of provider accountability for the information documented. The guideline also states that documentation of member-reported services must be complete (e.g., date, place of service, procedure, prescription, test result or finding, practitioner type). .	

Clinical Quality Domain	**Colorectal Cancer Screening (COL-E)**	**Posted 11/15/24**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** If a provider documents that a patient had a colonoscopy "one year ago" or "last year" with no exact month or date documented in a chart note, how should the date of service be entered for non-standard data? **Response:** The measure steward**,** NCQA, is not prescriptive regarding default dates. It is up to the organization to develop a method for assigning the date of service. Note that documentation with an approximated date may be used for reporting if it is specific enough to determine that the event occurred during the measure's specified timeframe. Please see Date Specificity in the Guidance section of the measure.	

General Guidelines	Member-Collected Samples	Posted 10/15/24
Commercial HMO/POS, Medi-Cal Managed Care	**Question:** Can samples collected at home by a patient and then sent to a lab count towards the numerator for the Cervical Cancer Screening (CCS-E) and Chlamydia Screening (CHL) measures? **Response:** Yes, for MY 2024 AMP reporting and beyond, the Member-Collected Samples General Guideline was updated to allow at home tests HPV and chlamydia tests that are processed by a laboratory or a provider's offices. The inclusion of at-home HPV and chlamydia tests, provided they are sent to a laboratory or a provider's office for analysis, will satisfy the CCS-E and CHL measures, respectively.	
Clinical Quality Domain	**Colorectal Cancer Screening (COL-E)**	**Posted 10/15/24**
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 2025, can an FDA approved blood test be used when reporting the COL-E measure? **Response:** The Colorectal Cancer Screening (COL-E) measure is based on the US Preventive Services Task Force (USPSTF) guidelines for colorectal cancer screening. The guidelines do not recommend serum (blood) testing (e.g., blood-based biomarker) and for this reason it does not meet criteria for the measure. The measure steward, NCQA, continually monitors clinical practice guidelines as they are updated.	
General	**Exclusion for Members Living Long-Term in an Institution (LTI)**	**Posted 9/13/2024**
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 reporting and beyond, how can the LTI exclusion be identified? **Response:** Only the LTI flag in the Monthly Membership Detail Data File may be used when identifying this exclusion. No other data sources may be used. For AMP reporting, the exclusion for members living LTI is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.	
Clinical Quality Domain	**Colorectal Cancer Screening (COL-E)**	**Posted 8/15/2024**
Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care	**Question:** For MY 2024 reporting and beyond, 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. For the COL-E measure, medical record data is considered supplemental data and must meet the criteria listed in General Guideline 27: Supplemental Data. The information/documentation in the supplemental data source must be clinically synonymous with the codes in the measure's numerator value sets.	
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 and beyond 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	**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, 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 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 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.	

Digital Measure Packages	ECDS Measures	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.	