Integrated Healthcare Association

Frequently Asked Questions

Align. Measure. Perform. (AMP) Programs

September 2021

General	General Guideline 30: What Services Count? and Appropriate Resource Use Domain Overview	Posted 9/15/2021
	Question: Does Onpoint accept denied and unpaid claims as part of HP data submission? **Answer:** Yes, for MY 2021 and beyond, HPs are expected to submit data for all services (including denied and unpaid claims) to Onpoint, as part of AMP data submission. Onpoint will generate measure results following the guidelines for HEDIS Utilization and Risk-adjusted measures. General Guideline 30 ("What Services Count?") and the Appropriate Resource Use Domain Overview will be updated to reflect this guidance in the MY 2022 AMP Technical Specifications.	
General	**PCS Questions**	**Posted 9/15/2021**
	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 Commercial ACO	*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**
	Note: This FAQ was released for HEDIS and applies to the AMP programs.	

Commercial HMO Commercial ACO	**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.	
Data Quality	**Encounter Timeliness**	**Posted 8/13/2021**
	Question: The ENLAG measure description was updated to clarify "Average Lagtime by Service Date" and "Average Lagtime by Paid/Remittance Date." However, the calculation of encounter timeliness average lagtime still specifies "Average Lagtime by Service Date" and "Average Lagtime by Submission Date." Can you clarify whether we should estimate lagtime using the submission date (i.e., the date we submit the claim to the health plans) or the paid/remittance date (i.e., the date we paid the claim)? **Answer:** Paid/remittance date should be used to estimate lagtime for the ENLAG measure specification, instead of submission date. Step 2 of the Encounter Timeliness Average Lagtime Calculation should state: "*Calculate the average lagtime by paid/remittance date.* For all encounters/claims with a paid/remittance date occurring January 1 – December 31 of the measurement year, identify the average lagtime of all claims/encounters in days for claims/encounters with a service date prior to the measurement year and during the measurement year. For each claim/encounter type, sum the lag times across all claims/encounters and divide by the count of all claims/encounters." This was a transcription error and will be updated in the MY 2022 AMP Technical Specifications.	
Clinical	**Colorectal Cancer Screening**	**Posted 7/16/2021**
	Note: This FAQ was released for HEDIS and applies to the AMP programs. **Question:** On May 18, 2021, the U.S. Preventive Services Task Force (USPSTF) updated the colorectal cancer screening recommendations to screen for colorectal cancer in adults aged 45 to 49 years. Will the COL measure be updated to coincide with the USPSTF recommendations that lower the screening age to 45? If yes, what measurement year can we expect this change to be reflected in the measure specs? **Answer:** NCQA is aware of updates to the US Preventive Services Task Force (USPSTF) guidelines for colorectal cancer screening. Given these updates, NCQA will evaluate potential changes to the HEDIS Colorectal Cancer Screening (COL) measure through input from clinical and technical measurement advisory panels, the Committee on Performance Measurement and public comment. Any potential changes to the measure resulting from this evaluation would be included in the Final AMP MY 2022 Technical Specifications at the earliest.	
General	**General Guideline 23: AMP Commercial ACO Continuous Enrollment**	**Posted 5/20/2021**
	Question: How are continuous enrollment and member attribution determined differently for Onpoint-generated results using health plan data in the AMP Commercial ACO program than in the AMP Commercial HMO program? **Answer:** The AMP Commercial ACO program does not apply continuous enrollment at the plan-PO level for Onpoint-generated results using health plan data, as the AMP Commercial HMO program does. For Onpoint-generated AMP Commercial ACO results, continuous enrollment specifies the minimum amount	

	of time a member must be enrolled in the *health plan* (not the specific ACO) before becoming eligible for a measure. The member must also be continuously enrolled in the benefit specified for each measure (e.g., medical and/or pharmacy), accounting for any allowable gaps, to be considered continuously enrolled. For Commercial ACO attribution, participating plans' own attribution or assignment of members is leveraged. Once continuous enrollment criteria have been met for a measure at the plan level, the "Frequency and Last Record Hierarchy" approach is used to attribute a member to an ACO. The ACOs are ranked based on length of enrollment for a member for the measurement year and then attributed to the ACO they are affiliated with for longest time. If a member belongs to more than one ACO for equal time, a tiebreaker is determined using the most recent ACO the member was associated with. **To note, because of differences in data capture and approach, health plan results generated by Onpoint and self-reporting ACO results may differ.** Continuous enrollment and member attribution for Onpoint-generated results in AMP Commercial ACO have not changed for MY2020 and have been applied as described above since the program's inception. This answer is intended to provide clarity to participants on General Guideline 23 in the MY2020 AMP Manual. AMP staff and Onpoint have revised General Guideline 23 for the Final MY2021 Technical Specifications, to be released June 1, 2021, to be consistent with this answer.	
Clinical	**Appropriate Testing for Pharyngitis**	**Posted 5/20/2021**
Commercial HMO Commercial ACO Medi-Cal Managed Care	*This FAQ is based off the HEDIS MY2020 Measure Trending Determinations **Question**: Can you clarify that Step 8 of the event/diagnosis is no longer applicable and de-duplication is not needed? **Answer**: The deletion of Step 8 of the event/diagnosis was an unintended change, considering there are scenarios when it is needed to de-duplicate episodes, when identifying the event/diagnosis. Due to this change, episodes that would have been excluded in the past using the deduplication instructions in step 8 are now included in the measure for MY2020 and MY2021. This was an unintended change that will allow more episodes to be included in the denominator. Step 8 will be recommended to be added back to the measure for MY2022.	
Data Quality	**Encounter Rate by Service Type**	**Posted 5/20/2021**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	**Question**: Should the denominator for ENRST measure be member months in MY 2020? If the ENRST denominator is member months, should ENRST rates be reported using the member months denominator, or should organizations calculate member years internally and provide rates based on the internally derived member years? **Answer**: The denominator for ENRST measure should be submitted to IHA (via TransUnion) as member months for MY 2020, and rates for the TransUnion submission should also be calculated based on the member months denominator. After submission, IHA will recalculate the denominator data as member years per the calculation described in the specification in the AMP MY 2020 Manual (this is to ensure that the final member years calculation and rounding rule is unified). Following MY 2020 data reporting, the final MY 2020 reports released to AMP participants will reflect the member years denominator calculation and rates based on the member years denominator for this measure.	
General	**General Guideline 17: Deceased Members**	**Posted 2/15/2021**
	Question: General Guideline 17 notes that deceased members may "not" be excluded from the PDC, SUPD, COB, AMB, FSP, and IPU measures. There are measures very similar to these Utilization measures not included in this list, can you confirm if this list is comprehensive and what is the guidance for similar measures? **Answer**: Deceased members may not be excluded from the Encounter Data Quality measures (ENRST, ENFMT, ENLAG) and Utilization measures (inclusive of GRX and OSU).	

	For the Data Quality measures, GRX and OSU specifically, deceased members are not excluded if the member had 1+ months of both medical and pharmacy coverage. Organizations may exclude deceased members from the Data Quality measures, GRX and OSU if the member had < 1 month of medical and pharmacy coverage. For the PQA and HEDIS Utilization measures (PDC, SUPD, COB, AMB, FSP, and IPU) currently listed in General Guideline 17, organizations are expected to include all deceased members. The list of measures noted in General Guideline 17 will be updated in the Final MY2021 Technical Specifications, slated to be released on June 1.	
General	**General Guideline 13: Members with Dual Enrollment**	**Posted 1/15/2021**
	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 Medicaid and Medicare 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**
	Note: This FAQ was released for HEDIS and applies to the AMP programs. **Question**: When a member has dual Medicaid/Medicare enrollment, how long must the member be enrolled in Medicare to be removed from the Medicaid 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	**Statin Use in Persons with Diabetes**	**Posted 1/15/2021**
Medicare Advantage	**Question**: A new requirement was added in the Event/Diagnosis Step 4 of the SUPD measure – Identify members with an IPSD that occurs ≥90 days prior to the end of the measurement year. What is the definition of IPSD for this measure? **Answer**: For the SUPD measure, the IPSD is defined as the earliest date of service for a diabetes medication during the measurement year.	
Appropriate Resource Use	**Frequency of Selected Procedures**	**Posted 1/15/2021**
Commercial HMO Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: Are members with unknown or third gender excluded from member months tables that only designate binary gender? **Answer**: Yes. Members with unknown or non-binary gender are excluded from only the utilization measures that require a specific gender (male or female) because the measure requires a gender to be assigned in the reporting tables (applies to the FSP measure only for AMP). NCQA continues to track industry standards for non-binary gender.	
Clinical	**Controlling High Blood Pressure and Comprehensive Diabetes Care – BP Control**	**Posted**

Commercial HMO Commercial ACO 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 Commercial ACO	*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" on page 227 of the Final MY 2020 Manual.	
General	**General Guideline 32 – Date of Service for Laboratory Tests**	**Posted 12/15/2020**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	**Question**: Per the recent updates to General Guideline 32, for tests in which the collected date and the resulted date span two different measure years (e.g., collected date is 12/31/2020 and resulted date is 1/2/2021, is it the resulted date that must be used for supplemental data entry? **Answer**: When the collection date is in the measurement year (i.e., 12/31/2020) and the result date is in the year after the measurement year (i.e., 1/2/2021), and the dates are within seven days, this can be considered the same test (Per General Guideline 32). The result is present, and the collection date is eligible for use, making the member numerator compliant. The collection date (12/31/2020) can be used with the result from 1/2/2021 for MY 2020 reporting, in this example.	
Clinical	**Child and Adolescent Well-Care Visits**	**Posted 9/15/2020**
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	**Child and Adolescent Well-Care Visits**	**Posted 9/15/2020**
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 Draft AMP MY 2020 and MY 2021 manual.	
Clinical	**Controlling High Blood Pressure and Comprehensive Diabetes Care**	**Posted 9/15/2020**
Commercial HMO Commercial ACO 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 39*? **Answer**: No. BPs taken by the member do not need to meet requirements for member-reported data described in *General Guideline 39* (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 (bullets at the bottom of page 73 and 79 of the Draft AMP MY 2020 and MY 2021 manual).	
Clinical	**Childhood Immunization Status**	**Posted 9/15/2020**
Commercial HMO Commercial ACO 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	**Statin Use in Persons with Diabetes**	**Posted 9/15/2020**
Medicare Advantage	**Question**: The Draft AMP MY 2020 and MY 2021 manual updates for the SUPD measure notes: "Added requirement that IPSD occurs ≥ 90 days prior to the end of the measurement year."; however, this update is not reflected in the specification. Can you confirm? **Answer**: Step 4 of the Event/Diagnosis criteria for the SUPD measure should note "Identify members with an IPSD that occurs ≥90 days prior to the end of the measurement year", before the step for identifying members who meet exclusions. This was a transcription error and omitted during the manual updates. We have noted this and will rectify in the Final MY 2020 Manual.	
Clinical	**Palliative Care Exclusion (Cross-cutting)**	**Posted 9/15/2020**
Commercial HMO Commercial ACO 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, medical record and supplemental data may also be used. If a member is identified as being in palliative care using medical record data, the member must be removed from the sample and replaced with a member from the oversample. If organizations use supplemental data to remove members in palliative care, they must follow the supplemental data guidelines (*General Guideline 31*). Count these members in the "Number of required exclusions" data element.	
Clinical	**Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis – MY2019 Clinical Quality Questions and Appeals**	**Posted 6/3/2020**

Commercial HMO	**Question**: We noticed the PO self-reported rates and health plan reported rates for the AAB measure were not inverted in the MY2019 preliminary results file downloaded on 05/29; however, the data appearing on IHA's analytics website is different. Can you confirm which is the most updated result? **Answer**: Following the release of the AMP MY2019 preliminary clinical reports on 05/29, IHA identified an issue with the inversion of all AAB reported rates. IHA has resolved this and updated the data, as well as all affiliated downloads, to accurately reflect participants preliminary results.	
Clinical	**Controlling High Blood Pressure – Use of Telehealth**	**Posted 4/15/2020**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	**Question**: Due to the COVID-19 crisis, providers are using telehealth visits to manage patients with non-urgent needs. If a patient is able to obtain their blood pressure (BP), under guidance and visual monitoring of the provider (i.e. during a video conferencing call), could this be used for MY2020 AMP reporting? **Answer**: Currently, the measure requires documentation that clearly states the BP taken using a remote monitoring device must be digitally stored and transmitted to the provider for interpretation. NCQA is not prescriptive regarding the format of the transmission or how the BP must be transmitted to the provider. However, the BP information must be transmitted from the device directly to the provider, or a device print out/download be emailed to the provider. That said, NCQA is reviewing telehealth guidance for measurement year 2020, and will discuss any updates with expert panels prior to the next revision of the measure specifications.	
General	**MY 2019 Health Plan Audited Clinical Measure Data File Layout**	**Posted 3/16/2020**
Commercial HMO Medicare Advantage Medi-Cal Managed Care	**Question**: In the "Sample HP File – Comm Only" tab of the MY2019 Health Plan Clinical File, we noticed a discrepancy in the HP SubID column. The ID below (Cell E194) for the ENRSTOV rate is "06", should this be "05" to align with other SubIDs for the ENRST reporting? DTL | DMHCID | SubID | Commercial HMO Enrollment | Commercial POS Enrollment DTL | 22222 | 06 | 33234 | 3245 **Answer**: Yes, this was a transcription error during the development of the data file. The SubID should be "05" in alignment with the other measures reported by the sample health plan. *Please note* – the data provided represents a sample health plan submission with dummy data; health plans are expected to input their own submission IDs, enrollment data and rates for each measure being reported.	
General	**MY 2019 Health Plan Audited Clinical Measure Data File Layout**	**Posted 2/27/2020**
Commercial HMO Medicare Advantage Medi-Cal Managed Care	**Question:** The overall professional encounter rate in the ENRST measure specs is the sum of rates 1, 2, 3, 4a, and 5a. However, the overall professional encounter rate in the data file layouts says that the professional encounter rate includes 1, 2, 3, 4a, 4b, 5a and 5b. Do we include 4b and 5b in the overall professional rate for MY2019 reporting? **Answer:** The ENRSTOVPROF rate should include the sum of rates 1, 2, 3, 4a, and 5a, as specified in the MY2019 Manual. This was a transcription error during the development of the MY2019 Data File Layouts, an updated MY2019 *Health Plan Audited Clinical Measure Data File Layout* will be released to reflect the accurate rates.	
General	**MY 2019 Health Plan Audited Clinical Measure Data File Layout**	**Posted 2/27/2020**
Commercial HMO Medicare Advantage	**Question:** There is no indication in the measure specs of an overall encounter rate (ENRSTOV), but it is in the data file layout and includes the sum of rates 1, 2, 3, 4a, 5a, and 6. Can you confirm this is correct?	

Medi-Cal Managed Care	**Answer:** The ENRSTOV rate was added to the ENRST measure for MY2019; we will update the measure specification in the next revision of the AMP manual to reflect this rate. Health plans are expected to report the ENRSTOV rate for MY2019.	
General	**MY 2019 Health Plan Audited Clinical Measure Data File Layout**	**Posted 2/27/2020**
Commercial HMO Medicare Advantage Medi-Cal Managed Care	**Question:** The "Audit Results Table" (tab 3) of the *Health Plan Audited Clinical Measure Data File Layout* does not include a Rate/Result Field for Small Denominator (SD) but "Sample HP File-Comm Only" (tab 5) and "Sample HP File-MediCal Only" (tab 7) do include "SD" in the rate column. Is "SD" a valid Rate/Result for health plans reporting on behalf of a PO with a denominator less than 30? **Answer:** No. Small Denominator ("SD") is not a valid Rate/Result for health plan clinical data because IHA aggregates all health plan/PO data together for final PO clinical results. If a health plan reports a measure with a denominator of less than 30, the health plan should also report the numerical rate for that measure (i.e., do not report "SD" as the rate). The "SD" indicated in the "Sample" tabs is an error and will be revised in an updated release of the *Health Plan Audited Clinical Measure Data File Layout*.	
General	**General Guideline 17: Deceased Members**	**Posted 2/14/2020**
	Question: Can deceased members be excluded from the COB, PDC and SUPD measures? **Answer:** No. Members who die during the measurement year are not excluded from the COB, PDC and SUPD measures. General Guideline 17 does not apply to these measures.	
Clinical	**Breast Cancer Screening**	**Posted 2/14/2020**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	**Question:** For age stratification, the manual states 'Medicare and Commercial product lines: 52–74 years', what about the Medi-Cal managed care product line? Do we need to apply the same age criteria? **Answer:** Yes. The age stratification for the BCS measure is women 52–74 years as of December 31 of the measurement year, for all product lines. This was a transcription error and will be updated in the next manual revision.	
Clinical	**Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis**	**Posted 2/14/2020**
Medicare Advantage	**Question:** The measure specification has a note "The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File." Do POs only apply the exclusion if they have the LTI data or a PO may decide whether or not to apply the exclusion regardless of their data access? **Answer:** The LTI exclusions are optional for physician organizations in the AMP program. This is a modification from HEDIS (as stated in the AMP program manual) and was made based on the consideration that some POs do not have access to the LTI monthly membership data file. That said, if a PO has access to the monthly membership data file, it is strongly encouraged that the PO apply the exclusion but ultimately the PO determines whether to apply the optional exclusion.	
Clinical	**Prenatal and Postpartum Care**	**Posted 2/14/2020**
Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** For members whose last enrollment start date is less than 42 days prior to delivery, should we include prenatal visits that occur after the delivery date but within 42 days after the enrollment start date?	

	Answer: No. The intent is to only count prenatal visits, which by definition can only occur prior to delivery. Do not count visits that occur on or after the date of delivery for the Timeliness of Prenatal Care indicator.	
Clinical	**Childhood Immunization Status/Immunizations for Adolescents**	**Posted 1/15/2020**
Commercial HMO Commercial ACO 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	**Cervical Cancer Overscreening**	**Posted 1/15/2020**
Commercial HMO Commercial ACO 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 34." Does this general guideline also apply to hrHPV tests? **Answer:** The guidance applies to both cervical cytology and high-risk HPV test. If two or more claims for hrHPV testing occur within 14 days of each other, count only the first one.	
Clinical	**Avoidance of Antibiotic Treatment for Bronchitis/Bronchiolitis**	**Posted 1/15/2020**
Commercial HMO Commercial ACO Medi-Cal Managed Care	**Question:** The AAB measure description was revised for the MY2019 manual, and no longer contains the same language as previous specifications. Are POs/health plans expected to report the inverted rate? **Answer:** No, the measure rates are inverted after submission. POs and health plans are expected to report direct rates.	
General	**AMP Audit Review Guidelines**	**Posted 12/16/2019**
	Question: We noticed a technical update was released for the HEDIS 2020 Audit Compliance and Align. Measure. Perform. Audit Review Guidelines, does the version on the IHA website reflect these updates? **Answer: Yes.** The 2019 AMP Audit Review Guidelines were updated on December 13th and posted on the IHA website linked here: https://www.iha.org/sites/default/files/resources/my_2019_amp_audit_manual_dec_2019_update.pdf	
General	**HEDIS Medication List Directory**	**Posted 12/16/2019**
	Question: The HEDIS Medication List Directory is no longer linked on the NCQA website as stated in the MY 2019 manual, where can organizations access this? **Answer:** The HEDIS Medication List Directory (MLD) was previously available for download on the NCQA website, but is now available for download at no charge in the NCQA Store linked here: http://store.ncqa.org/index.php/catalog/product/view/id/3741/s/hedis-2020-ndc Once you have requested an order, the MLD will be made available in the ***My Downloads*** section of your My.NCQA account.	
General	**General Guideline 32: Measures That Require Results From the Most Recent Test**	**Posted 12/16/2019**
Commercial HMO Commercial ACO Medicare Advantage	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** With *General Guideline 32*, organizations must use the most recent date when multiple dates of service for the same lab test are provided within a 7-day period. Which test is used in the following	

Medi-Cal Managed Care	example, the September test or the December test? A HbA1c lab claim on 12/30/2019 had a result date in the medical record on 1/3/2020. The member also had an HbA1c test with both the test and a result on 9/30/19. **Answer:** Using *General Guideline 32*, the 12/30/2019 test is used as the most recent test while the 1/3/2020 result is within 7 days of the test, it is after the date threshold in the measure and may not be used. The result is counted as missing and the member is compliant for the HbA1c Testing and HbA1c Poor Control indicators. The member is not compliant for the HbA1c Control <7 for Selected Populations and HbA1c Control <8 indicators. The 9/30/2019 test cannot be used as it is not the most recent. ***Note:** Ensuring results in the year after the measurement year are not counted is not tested in AMP MY 2019 Measure Certification.*	
General	**General Guideline 35: Measures That Use Medication Lists**	**Posted 12/16/2019**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question:** *General Guideline 35* states that if an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, to avoid double counting, deduplicate and count an NDC code and an RxNorm code for the same drug on the same date of service as only one dispensing event. If a measure specification says, "if multiple prescriptions for the same medication are dispensed on the same day, sum the days supply," should the days supply from the pharmacy data event and the clinical data event be summed? **Answer:** The intent of *General Guideline 35* is to prevent double-counting when an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, because the same dispensing event can have both an NDC code in the pharmacy data and an RxNorm code in the clinical data. Because the two codes identify the same dispensing event (not two dispensing events), count an NDC code and an RxNorm code on the same date of service as one dispensing event and do not sum the days supply.	
General	**General Guideline 49: Mapping Proprietary or Other Codes**	**Posted 12/16/2019**
Commercial HMO Commercial ACO 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 "subcutaneous" in the Asthma Controller Medications table (p. 132 MY 2019 AMP Program Manual). The MLD contains two generic products for benralizumab: "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	**Prenatal and Postpartum Care**	**Posted 12/16/2019**

Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: The PPC measure defines an enrollment segment as a period of continuous enrollment with no gaps. The "last enrollment segment" is used in calculating the timelines of prenatal care numerator and is defined as the enrollment segment during the pregnancy with a start date closest to the delivery date. How do organizations identify the last enrollment segment for a member who has multiple enrollment segments? **Answer**: For AMP MY 2019 reporting, enrollment segments are determined based on enrollment data provided by the health plan. If a plan provides the member's enrollment in different products/product lines as different enrollment segments, or even enrollment in the same product/product lines as different enrollment segments, the start date of the last enrollment segment must be used.	

Clinical	**The "Route" column in the Asthma Medication Ratio measure**	**Posted 12/16/2019**
Commercial HMO Commercial ACO 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."*	

Clinical	**Childhood Immunization Status**	**Posted 12/16/2019**
Commercial HMO Commercial ACO Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: The third bullet in the Rotavirus numerator description references Rotavirus (2 Dose Schedule) Procedure Value Set, which does not exist in the Value Set Directory. Which value set should be used for reporting? **Answer**: Replace the value set reference with "Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set" and use this value set for reporting.	

Clinical	**Comprehensive Diabetes Care and Osteoporosis Management in Women Who Had a Fracture**	**Posted 12/16/2019**
Commercial HMO Commercial ACO Medi-Cal Managed Care Medicare Advantage	**Question**: We noticed a discrepancy in the requirements for advanced illness exclusion, in the CDC and OMW measures. The specs are slightly different from other measures with the same exclusion. Can you confirm if this is accurate or if it is a transcript error? **Answer**: This is a transcription error, which was not identified during the MY2019 manual updates. The requirements for identifying/excluding members with advanced illness should follow the same steps (see below) as specified in the CBP, SPC, SPD, ART, BCS and COL measures. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded: 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the intake period through the end of during the measurement year. 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): a. At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the	

diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
    i. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    ii. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
    iii. Identify the discharge date for the stay.
b. At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
c. At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
    i. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    ii. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
    iii. Identify the discharge date for the stay.
d. A dispensed dementia medication (Dementia Medications List).

General	**General Guideline 35**	**Posted 11/15/2019**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: *General Guideline 35* states that if organizations use both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, they should deduplicate and count an NDC code and an RxNorm code for the same drug on the same date of service as only one dispensing event, to avoid double counting. How should organizations handle this where different drugs are included in the same medication list with no variable to differentiate between "same or different"? **Answer**: For measures where different drugs are included in the same medication list with no variable to differentiate between "same or different," the organization develops its own method. It is appropriate for the organization to assume that an NDC code and an RxNorm code on the same date of service are for the "same drug" and count as one dispensing event; however, this will not be tested as part of measure certification.	

Clinical	**Comprehensive Diabetes Care**	**Posted 11/15/2019**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: Does documentation of "HB1c" meet criteria when reporting the HbA1c testing indicator? **Answer**: Yes, documentation of " HB1c " is considered evidence of a HbA1c test and may be used when reporting the HbA1c testing indicator.	

Clinical	**Prenatal and Postpartum Care**	**Posted 11/15/2019**
Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: The Postpartum Care indicator states that documentation of "Resumption of physical activity and attainment of healthy weight" meets criteria. Does documentation need to include both resumption of physical activity AND attainment of healthy weight to meet criteria? **Answer**: No. Documentation of either resumption of physical activity or attainment of healthy weight alone meets criteria.	

General	**Codes Found in Medical Records**	**Posted 10/23/2019**
Commercial HMO Commercial ACO Medicare Advantage	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **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?	

Medi-Cal Managed Care	**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.	
General	**General Guideline 17: Deceased Members**	**Posted 10/23/2019**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: Is General Guideline 17: Deceased Members an optional exclusion? Must a deceased member be removed from all measures? **Answer**: The exclusion in General Guideline 17 is optional. Members who die during the measurement year may be excluded from all measures, except the measures in the Risk Adjusted Utilization subdomain. However, if a member dies during the measurement year, the organization is not required to remove the member from all measures. For example, if an organization identifies a deceased member during medical record review for the ABA measure, the member may be removed from the measure as a valid data error and replaced with a member from the oversample, but the organization is not required to remove the member from all other applicable measures. Additionally, there is no requirement to assess numerator compliance for deceased members and exclude the member only if they are not numerator compliant. We are not prescriptive of how organizations identify deceased members using claim/encounter and enrollment data. Organizations must develop their own methods to identify these members.	
Clinical	**Pharmacy Data**	**Posted 10/23/2019**
Commercial HMO Commercial ACO Medicare Advantage Medi-Cal Managed Care	*Note: This FAQ was released for HEDIS and applies to the AMP programs.* **Question**: 1. If pharmacy data are classified as supplemental and the medication dispensed date is not documented, may the “shipped date” be used as the “dispensed date”? 2. If pharmacy data are classified as supplemental, may the date when a provider gives free medication samples to a member be considered the “dispensed date”? **Answer**: 3. No. The “shipped date” may not be used as “dispensed date” date when reporting the pharmacy measures. 4. Yes. The date when the provider gives the medical sample to the member is considered the “dispensed date” when reporting pharmacy measures.	