IHA

Align. Measure. Perform.
2022 Public Comments and Responses

#	Element Name	Org Type	Support Type	Comment	Response
				General IHA Program Updates	
1	Alignment with California Department of Managed Health Care (DMHC) Health Equity and Quality measure set	PO	Support with Modifications	[PO] supports alignment of IHA measurement programs with other key external initiatives toward the common goal of reducing health disparities and promoting health equity. However, we have concerns with current DMHC draft recommendations in its ability to reduce health disparities and reduce participant reporting burden. Instead, we recommend that IHA align with NCQA RES measure set; segmentation of measures by race/ethnicity will need continued thoughtful analysis over time to ensure adequate population denominators and appropriateness of focus for gap closure. Please note our outlined concerns of recent DMHC proposal: 1). Plans would benefit from further clarity about the accuracy/validity of segmenting a measure that is risk adjusted (PCR) or measures with very small denominators (CAHPS), especially when NCQA has avoided segmentation of measures with these characteristics. 2). Please clarifying how many months a plan will have to set appropriate targets and conduct performance improvement to reach the goals. For example, will MY 2023 or MY 2024 performance be used to set targets for MY 2025? The MY 2024 data will be submitted in 2025 and benchmarks are not available until mid-year. Most health plans in 2025 will analyze performance against benchmarks in Q3-4 to guide performance improvement priorities and set targets for MY 2026. This timeline will allow the medical groups a full year to conduct PDSA rapid improvement efforts. This is especially important for plans that will have many measures to improve. The sheer volume of measures will be influenced by the pending decision to use the 25th percentile or 50th percentile for benchmarks. 3). The appendix models the number of measures commercial and Medicaid plans may have for equity performance improvement with significant impact to Medicaid plans. The document should include a discussion of any unintended consequences of shifting funding away from Medicaid plans that may further increase disparity gaps. Such a discussion may influence the committee’s decision on the benchmarks, the number of measures, and which MY results will guide MY 2025 targets. 4). NCQA requires 9/13 measures to be stratified by race/ethnicity, but there are 4 additional measures that require significant health plan reporting burden (PCR, CAHPS, DSF, CIS). The document would benefit from more clarification of the benefit of adding this measurement burden at this time. 5). Given #1 and #4 regarding CAHPS, did the committee discuss DMHC’s oversite of objective data regarding access to care and how that may be more accurate than member perception of “getting needed care” along with geographical variations across the US?	Thank you for your comment. IHA's proposed changes to align the AMP Measure Set with the DMHC Health Equity and Quality measure set also moves AMP towards increased alignment with the NCQA RES measure set and other key external initiatives, such as DHCS' Managed Care Accountability Set (MCAS). IHA and its committees have carefully considered the appropriateness of adding specific measures to the AMP measure set; for example, the AMP measure set will not include the HP-CAHPS "Getting needed care" composite recommended for DMHC because it is not designed or validated for use at the PO level. As of October 2022, the DMHC Health Equity and Quality Committee (HEQC) has concluded its work to recommend a measure set and benchmarking approach to DMHC. DMHC held a public comment period earlier this year for feedback on the committee's recommendations, and it is anticipated that DMHC will release its final decisions regarding the committee's recommendations by the end of 2022. Materials and transcripts from the public committee meetings are available on DMHC’s website, and any questions or comments regarding DMHC's committee, decision process, or requirements should be directed to DMHC.
2	Advanced Primary Care (APC) pilot planning	PO	Do Not Support	*No additional comment.*	Thank you for your comment.

3	Advanced Primary Care (APC) pilot planning	PO	Do Not Support	We at [PO] are concerned that quality data collection at the primary care practice level will provide minimal actionable information, and potentially misleading information. More specifically: 1). The [PO] integrated model leverages the coordination of primary care, ancillary staff, and subspecialty departments in the care and management of CBP, HBD, COL, AMR, CIS, IMA. As a result, primary care panel rates do not represent the care coordination for quality within the system. 2). Primary care panels within our large group practice vary significantly by disease, age, gender, language, etc. based on the expertise of the clinician. As a result, variations of quality control rates are understood, expected, and managed more appropriately at the level of the larger group practice. 3). Lastly, we are concerned about the accuracy of provider level information for appropriate resource use, cost, and patient experience measurements (EDU, AHU, TCOC, CG-CAHPA); these are small volume initiatives that are significantly influenced by larger operational systems of clinics/hospitals and can yield misleading information at the provider level. For example, a clinic with urgent care support in the evening and weekends will affect ER utilization rates.	Thank you for your comment. IHA and CQC will take these concerns into consideration in continuing to plan the APC pilot. A key clarification is that this measurement would occur at the primary care practice level, not at the individual primary care provider level. There will also be a minimum number of attributed members required, as well as minimum denominator criteria to ensure reliable measurement results. The patient population across all practices can vary widely in terms of age, gender, race and ethnicity, chronic conditions, etc. Some of this is accounted for in the measurement itself, e.g., only assessing certain populations, stratifying results, or adjusting results to account for differences. Understanding performance variation, both good and bad, within and across delivery systems is important and provides context to highlight best practices and invest resources to support quality improvement. Practices also vary in terms of structure – some practices are independent, and others are part of a larger system with many of the services being done centrally and not at the actual practices. Practices of all sizes apply a team-based approach to chronic disease management, whether within their own four walls or with the support of a community of specialists.
MY 2023 Measure Retirements					
4	Frequency of Selected Procedures (FSP)	PO	Support	*No additional comment.*	Thank you for your support.
5	Frequency of Selected Procedures (FSP)	PO	Support	*No additional comment.*	Thank you for your support.
6	Weight Assessment & Counseling for Nutrition and Physical Activity for Children/ Adolescents: BMI Percentile Documentation (WCC)	Health Plan	Do Not Support	Hello, thank you for the opportunity to provide feedback. The WCC measure is part of the Covered California Policy for Removal from the Exchange (referred to as 25-2-2), which can be found here: https://hbex.coveredca.com/stakeholders/plan-management/library/25-2-2_Policy_Methodology_6-10-22.pdf. It is also part of the Quality Rating System (QRS) for the Exchange: https://www.cms.gov/files/document/2023-qrs-technical-specifications.pdf. Because WCC (BMI Percentile Documentation) is a provider-driven measure, I recommend keeping this measure in the MY 2023 AMP measure set for Commercial. Thank you for your consideration.	Thank you for your comment. The WCC BMI Percentile Documentation indicator was adopted in AMP Medi-Cal Managed Care to align with DHCS' Managed Care Accountability Set (MCAS), but has not been tested or adopted as part of AMP Commercial HMO. The TMC's recommendation to retire WCC from AMP Medi-Cal Managed Care was informed by the measure's retirement from MCAS for MY 2022. TMC members noted the use of WCC in the commercial landscape, including in QRS, and discussed whether to test WCC in AMP Commercial HMO. Ultimately, the TMC did not recommend testing WCC in AMP Commercial HMO because WCC (1) presented a lower clinical priority than other potential testing measures, and (2) did not align with DMHC's MY 2023 Health Equity and Quality measure set, which the TMC prioritized highly for alignment in AMP. Of note, WCC was tested in AMP Commercial ACO in MY 2018 and did not proceed to baseline data collection due to low performance.

7	Weight Assessment & Counseling for Nutrition and Physical Activity for Children/ Adolescents: BMI Percentile Documentation (WCC)	PO	Support	*No additional comment.*	Thank you for your support.
				MY 2023 Testing Measures	
8	Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	PO	Support with Modifications	Integrating depression screening into primary care is a best practice; however, the burden of capturing the follow plan is significant and falsely lowers a PO performance due to this data gap. I support this measure but request to analyze if we could just use the screening portion of the measure.	Thank you for your comment. IHA will test both indicators (screening and follow-up) in the Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) measure in MY 2023. Following DSF-E's testing year, IHA will assess performance and anticipate performance results will identify and highlight any data gaps with PO self-reporting; however, we expect any such challenge will uniformly affect all organizations. As with all testing measures in AMP, IHA will carefully consider testing results for both indicators as well as participants' experiences of data reporting before including either indicator for any AMP accountability uses for POs such as incentive payments or awards.
9	Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	PO	Do Not Support	We at [PO] recommend postponement of IHA adoption of the DSF-E as a testing measure, until after NCQA has publicly reported national results for the DSF-E measure. Further testing and analysis by NCQA in 2023 will facilitate learnings on the measure. Delaying IHA adoption until after that point will also reduce reporting burden.	Thank you for your comment. The TMC recommended testing DSF-E in AMP for MY 2023 following previous postponement of its testing in AMP Commercial ACO in MY 2021. TMC members have expressed the need to not further postpone testing, given the clinical importance of depression screening as well as DSF-E's uptake in the measurement landscape, including in DHCS' Managed Care Accountability Set (MCAS) and DMHC's Health Equity and Quality measure set for MY 2023. As with all testing measures in AMP, reporting DSF-E measure results will be voluntary for MY 2023; IHA encourages reporting to better evaluate data gaps and challenges. IHA recognizes that testing DSF-E in AMP in MY 2023 will be a learning experience for AMP participants. IHA will carefully consider testing results as well as participants' experiences of data reporting before fully adopting DSF-E or including it for any AMP accountability uses such as incentive payments or awards.
10	Well-Child Visits in the First 30 Months of Life (W30)	PO	Support	*No additional comment.*	Thank you for your support.
11	Prenatal and Postpartum Care (PPC)	PO	Support	*No additional comment.*	Thank you for your support.

12	Transitions of Care (TRC)	PO	Support	*No additional comment.*	Thank you for your support.
MY 2023 Measure Specification Updates					
13	Race and Ethnicity Stratifications (RES)	PO	Support with Modifications	The health plans do not always provide this information to the POs. So POs may not have complete data as defined by the OMB. Adding more measures with this start is challenging for the POs.	Thank you for your comment. Transparency on performance by race and ethnicity is critical to evaluating and addressing disparities in health care quality, and IHA encourages race and ethnicity stratification (RES) data reporting for AMP. IHA will assess RES data reported for MY 2022 and anticipates that results will provide insight into data availability and reporting feasibility for both plans and provider organizations. IHA will carefully consider these factors before incorporating RES results into any AMP accountability uses for POs for future measurement years. Please note that direct and indirect data sources are allowed for reporting RES data; however, direct data sources (which includes EHR and enrollment data) are the preferred data source. General Guideline 31 in the AMP MY 2023 Technical Specifications provides a crosswalk for mapping RES data to the OMB categories specified for reporting the applicable HEDIS measures.
14	Race and Ethnicity Stratifications (RES)	PO	Support	*No additional comment.*	Thank you for your support.
15	Update Breast Cancer Screening (BCS) to an ECDS Measure (BCS-E)	PO	Do Not Support	Should be optional for the first year - added cost.	Thank you for your comment. It is an AMP program policy to align with the measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. NCQA is fully transitioning to BCS-E reporting for HEDIS in MY 2023 and will not maintain a non-ECDS version of BCS after MY 2022. In addition, ECDS reporting will allow more robust data sources and streamline supplemental data use for reporting the measure. All PO self-reporting of AMP results is voluntary. While IHA encourages POs to self-report measure results, including BCS-E, in order to improve the completeness and accuracy of their AMP results, POs may opt to not report any measure.
16	Update Breast Cancer Screening (BCS) to an ECDS Measure (BCS-E)	PO	Support	*No additional comment.*	Thank you for your support.
17	Alignment with other measure steward specification updates	Health Plan	Do Not Support	General Guideline updates needed for ACO. ACO - AMP Tech Specs: Pages 4-7 & 14-15 reference PO and health plan reporting of ACO at PO level (ACO ID#s, member identifier files, continuous enrollment and ACO PO attribution). ACO AMP sunsets after MY2021, Plans are not required to submit ACO member identifier files and will not be required to report ACO PO IDs in quarterly files ([Plan] will flag ACO members as being part of an ACO with "x"). Onpoint will not be able to attribute members to specific ACOs, just confirm the member is a part of an ACO.	Thank you for your comment. References to the former AMP Commercial ACO program will be removed from the Final MY 2023 AMP Technical Specifications. Guidance on future ACO data submission to support analyses outside of AMP, including those for the Atlas program, will be removed from the AMP Technical Specifications. This information will be finalized and documented separately and shared with participants at a later date. The Final MY 2022 AMP Program Guide, to be released on December 15, 2022, will also note that AMP participants are not expected to submit ACO data for AMP for MY 2022.

18	Alignment with other measure steward specification updates	Health Plan	Support with Modifications	General Guideline updates needed for Medi-Cal Managed Care. It does not appear that the continuous enrollment difference from Commercial HMO and Medi-Cal AMP referenced in the MY2022 AMP FAQ document were added to the MY2023 specifications (CE is at plan level and not plan and PO). Please include this to General Guidelines, section 21. Also, for every measure that includes Medi-Cal Managed care in "Product lines" the "Continuous Enrollment FOR HEALTH PLANS sections should read "Commercial HMO and Medicare: The measurement year in the health plan and the PO (parent level). Medi-Cal Managed Care: The measurement year in the health plan".	Thank you for your comment. Beginning with MY 2022, health plans and self-reporting POs will submit audited quality results for AMP Medi-Cal Managed Care through the TransUnion data pipeline. For the sake of alignment across product lines, continuous enrollment guidelines for this submission will align with AMP Commercial HMO and will be determined at the Plan and PO level, as is indicated in the MY 2022 and Draft MY 2023 Technical Specifications. IHA conducted an internal analysis of MY 2020 Medi-Cal data that indicated this continuous enrollment approach would produce valid results for AMP Medi-Cal Managed Care. AMP Medi-Cal Managed Care reporting and accountability uses for MY 2022 will utilize results submitted through the Transunion pipeline. Onpoint may also generate results for comparison purposes, but these results will not be used for accountability in AMP. The FAQ detailing Onpoint's methodology for determining continuous enrollment for AMP Medi-Cal Managed Care will be removed from the FAQ document after the AMP MY 2021 results release cycle as appropriate.
19	Alignment with other measure steward specification updates	PO	Support with Modifications	GLP1 RA and SGLT-2 I medications should be removed from the classes of drugs used to identify patients with diabetes. These drugs are no longer exclusively used to treat diabetes and now have other indications for use such as obesity and CHF. Inclusion of these medications results in the inclusion of patients in the diabetes measures denominators who do not have diabetes.	Thank you for your comment. It is an AMP program policy to align with the measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. NCQA is aware some medications included in the medication list for diabetes measures have recently been approved for the management of other conditions, and this will be taken into consideration during the next revision to these measures. The AMP program will align specifications based on any future revisions to the HEDIS measures.
20	Alignment with other measure steward specification updates	PO	Do Not Support	Dapagliflozin and empagliflozin single-ingredient products were removed from the SUPD measure this year due to FDA-approved non-diabetes indications (CHF). These meds have not been removed from the Diabetes Medication list so would still pull a patient into the CDC successor measures would like to see consistency with the different measure stewards.	Thank you for your comment. It is an AMP program policy to align with the measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. NCQA is aware some medications included in the medication list for diabetes measures have recently been approved for the management of other conditions, and this will be taken into consideration during the next revision to these measures. The AMP program will align specifications based on any future revisions to the HEDIS measures.
21	Alignment with other measure steward specification updates	PO	Support with Modifications	The PDC and SUPD medication lists do not match the other diabetes care measures diabetes medication lists. It makes it difficult to educate providers and their staff on the measures when they are very similar but not the same, and it would improve understanding of the measures if the medication lists were aligned. For example, empagliflozin single-ingredient products were removed from the SUPD measure due to FDA-approved non-diabetes indications, but not removed from other diabetes related measures. In addition, GIP Receptor Agonists were added to the PDC and SUPD measures, but not to the other diabetes care measures."	Thank you for your comment. It is an AMP program policy to align with the measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. Your comment has been noted and shared with the applicable measure stewards. Currently, the HEDIS diabetes measures do not include the GIP Receptor Agonists that were added to the Pharmacy Quality Alliance (PQA) SUPD and PDC measures in MY 2023; however, the measure leads will assess these medications for inclusion in a future update of the measure specifications, pending stakeholder review and feedback. Note that PQA measures are heavily dependent on pharmacy data, while the HEDIS measures allow the use of claims and other supplemental data. This may constitute unique differences in specification requirements between measure stewards.

22	Alignment with other measure steward specification updates	PO	Support	*No additional comment.*	Thank you for your support.
23	Alignment with other measure steward specification updates	PO	Support	*No additional comment.*	Thank you for your support.
			All Other Comments		
24	All Other Comments	PO	Support	Thank you for the opportunity to provide feedback on the IHA Draft Measurement Year (MY) 2023 AMP Measure Set and Technical Specifications. We have two areas related to pharmacy claims, medication utilization and drug costs we would like IHA to consider. 1) Drug prescribing: a) IHA may consider looking into the future and creating a “Biosimilar Utilization Rate” metric in the Measure Set. i) As additional innovator drug products lose patent protection, there will be greater opportunity to implement measures to reduce drug costs by increasing utilization of biosimilar products. ii) The increasing availability of biosimilar and interchangeable biological products can provide additional treatment options and enable greater access for more patients. This will result in a decrease in overall healthcare expenditures and total cost of patient care. 2) Pharmacy claims data and Diabetes related quality measures: The diabetes-related quality measure inclusion criteria should be revised so patients prescribed glucose-dependent insulinotropic polypeptide (GIP) and glucagon-like peptide-1 (GLP-1) agonists as solo antidiabetic agents are not included because these drugs are used to treat conditions other than diabetes; patients with diabetes on these medications should be identified through diagnosis codes only. Alternatively, the entire GIP/GLP-1 agonist drug class could be excluded from the list of Diabetes Medication that impact inclusion criteria for diabetes-related quality measures. GIP/GLP-1 agents within this class that do not carry the weight loss indication are prescribed “off label” to patients for weight management due to a variety of factors. The off-label use of these agents has grown by social media attention and a nationwide semaglutide shortage. Furthermore, positive preliminary Phase 3 clinical trial results of tirzepatide (Mounjaro) also contributes to this off-label utilization of GIP/GLP-1 agonists. Therefore, patients using GIP/GLP-1 agonists off-label for weight management should not be included in diabetes-related quality measures.	Thank you for your comment. 1) IHA appreciates your comment drawing our attention to biosimilar and interchangeable biological products, and the role they may play in driving down costs and improving patient access. As this healthcare innovation advances and more is learned about its impact and feasibility as a measure concept, IHA will consider the use of biosimilar utilization metrics in AMP as appropriate. 2) It is an AMP program policy to align with the measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. NCQA is aware some medications included in the medication list for diabetes measures have recently been approved for the management of other conditions, or are commonly prescribed "off label," and this will be taken into consideration during the next revision to these measures. The AMP program will align specifications based on any future revisions to the HEDIS measures.

25	All Other Comments	PO	Support with Modifications	Please add "history of myalgia" as an exclusion for the statin measures. Once a patient has experienced myalgias on a statin, it is exceedingly difficult (and sometimes inappropriate) to get them to try going on one again. It is my understanding that a myalgia-related diagnosis has to be coded in the measurement year but, unless we re-challenge the patient and they experience muscle aches again, it would be fraudulent billing to code it as an active condition. Thank you for your consideration.	Thank you for your comment. It is an AMP program policy to align with the measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. Your comment was reviewed by the measure steward (NCQA) and will be taken into consideration during the next revision to these measures. The AMP program will align specifications based on any future revisions to the HEDIS measure. For MY2023 reporting, the Statin Therapy for Patients With Cardiovascular Disease (SPC) and Statin Therapy for Patients With Diabetes (SPD) measures include an exclusion for members with myalgia, myositis, myopathy or rhabdomyolysis during the measurement year. However, an allergy or history of an intolerance to a statin medication is not considered an exclusion for the measure.
26	All Other Comments	PO	Support with Modifications	CBP-- CBP should be modified to exclude diabetic patients from the measure, as they were in CBPH, to avoid the same patient population being measured for the same thing in two different measures. Or retire the CDC- blood pressure measure. Thank you.	Thank you for your comment. It is an AMP program policy to align with measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. Your comments were reviewed by NCQA who provided the following response: The intent of the CBP measure is different from the BPD measure. In the CBP measure, the provider who is managing the member's hypertension is accountable for bringing the hypertension under control later in the year (i.e., the measure assesses members with a diagnosis of hypertension). The BPD measure focuses on management of hypertension in members with diabetes. While there is overlap in denominators for CBP and the BPD measure, evaluating hypertension management for members with hypertension and diabetes remains an important priority for IHA stakeholders.
27	All Other Comments	PO	Support with Modifications	The direction that medical record documentation must be "clinically synonymous" with codes in the value set is vague. Please add clarification of what "clinically synonymous" means.	Thank you for your comment. The addition of this language to General Guideline 30: Supplemental Data is intended to clarify expectations for supplemental data. The intent is that the services in the medical record could be billed using one of the codes in the value set (e.g., the service meets CPT requirements for billing the code). Documentation should provide enough detail that it is clear the intended service from the codes in the value set was provided. All supplemental data requires review and final approval by the auditor.
28	All Other Comments	Health Plan	Do Not Support	With IHA retiring the AMP ACO program, can you please explain why there is a Measure Set for AMP ACO MY2023? Understanding that IHA is still using ACO data for other reporting, leaving ACO AMP in the measure set can be misleading and somewhat implies there is still an active AMP program. If ACO must stay in the Measure Set view, can you please flag that LOB as a non-active AMP Program (IHA internal use only)?	Thank you for your comment. In the transition away from ACO-level reporting in AMP and toward using ACO data for other reporting, IHA has attempted to preserve ACO documentation to support future analyses as appropriate. As such, the Draft MY 2023 AMP Measure Set approved by the TMC and PGC still referenced an AMP Commercial ACO program. However, in assessing current ACO analysis planning, IHA agrees that it is appropriate to remove the AMP Commercial ACO Program from the Final MY 2023 Measure Set. The Final Measure Set will not include a separate Commercial ACO measure set.

29	All Other Comments	PO	Do Not Support	"At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year." We do not support the increase of two frailty codes used in MY to qualify for exclusion. Please provide explanation to why the increase change.	Thank you for your comment. It is an AMP program policy to align with the measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. Your comment was reviewed by the measure steward (NCQA), who provided the following response: During development of a new measure, where frailty was under consideration, NCQA found potential over-identification of members by the frailty value sets. Testing results showed that using at least two indications of frailty on multiple dates of service to specify frailty is more specific and may better identify those who are frail. For Measurement Year 2023, NCQA updated those measures that include the frailty exclusion to specify that at least two indications of frailty with different dates of service are required. NCQA saw only minor impacts on denominator size during testing and does not anticipate denominator increases resulting from the specification changes to be substantive. Furthermore, we expect any such increase to uniformly affect all organizations.
30	All Other Comments	PO	Do Not Support	SPD, SPC, SUPD, PDC- statin -- Issue applies to all statin measures, patients that are on a PCSK-9 should not be bound to these metrics (because they normally wouldn't be prescribed both a statin & a PCSK-9). PCSK med prescriptions should make patients excluded from these measures. Thank you.	Thank you for your comment. It is an AMP program policy to align with measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. Your comments were reviewed by the appropriate measures stewards (NCQA and PQA) who provided the following responses: The use of PCSK-9 medications was previously reviewed by our measurement experts and the consensus was to align with clinical guidance to not exclude patients on PCSK-9 medications for the following reasons: 1) NCQA found that PCSK-9 medications are common add-ons to statins, and excluding patients for their use would be complex given the measure's intent to assess statin adherence. 2) PQA measures, specifically, are intended for retrospective population-level analysis, and not intended to guide individual patient care decisions. NCQA and PQA measurement expert panels do not have evidence-based rationale to support the exclusion of patients receiving PCSK9 inhibitors. We will continue to monitor clinical guidelines and align with future updates.
31	All Other Comments	PO	Do Not Support	BCS measure - Our Oncologists and PCP wanted us to send in their concern, as they do not think it is appropriate to include patients who have a breast cancer diagnosis in the breast cancer screening measure. These patients imaging studies are usually more involved, such as PET, MRI, etc. than a typical screening mammogram.	Thank you for your comment. It is an AMP program policy to align with measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. Your comments were reviewed by the measure steward (NCQA) who provided the following response: The Breast Cancer Screening (BCS-E) measure is based on the US Preventive Services Task Force Guidelines (USPSTF) and the American Cancer Society Guidelines, which evaluate screening for the general population of women and thus do not include higher levels of diagnostic testing. Although MRIs, PETs and other procedures may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes, they are performed as an adjunct to mammography. For BCS-E, members with breast cancer or a history of breast cancer may not be excluded because it is expected that women who complete treatment would resume routine mammogram screenings. We will continue to monitor clinical guidelines and align with future updates.

32	All Other Comments	PO	Do Not Support	Clinically Synonymous: It is not clear what "clinically synonymous" means in the new note stating medical record documentation must be "clinically synonymous" with codes in the value set. May be able to support measure with more detail as to what constitutes clinically synonymous" examples would be helpful. For example, Do the dx code/procedure description words need to match exactly in the documentation? Example if a screening colonoscopy was done and the colonoscopy procedure notes indicate poly with removed and sent for bx but just the generic diagnostic colonoscopy code was submitted - not the code for colonoscopy with polyp removal. would we be able to use the code/ documentation for reporting or is the Example - if code for colonoscopy done through stoma is submitted but the colonoscopy note in chart reflects that the colonoscopy was done per usual way- through rectum and pt has no stoma than that colonoscopy code and note could not be used for reporting? all example codes mentioned above are in the value set.	Thank you for your comment. The addition of this language to General Guideline 30: Supplemental Data is intended to clarify expectations for supplemental data. The intent is that the services in the medical record could be billed using one of the codes in the value set (e.g., the service meets CPT requirements for billing the code). Documentation should provide enough detail that it is clear the intended service from the codes in the value set was provided. In your example above the notation of “colonoscopy” alone meets criteria, as this is clinically synonymous with ICD-9 45.23 (Colonoscopy) and SNOMED 73761001 (Colonoscopy (procedure)). All supplemental data requires review and final approval by the auditor.
33	All Other Comments	PO	Do Not Support	It is difficult to get a single indicator of frailty. Do not support the updated requirement for two indicators.	Thank you for your comment. It is an AMP program policy to align with the measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. Your comment was reviewed by the measure steward (NCQA), who provided the following response: During development of a new measure, where frailty was under consideration, NCQA found potential over-identification of members by the frailty value sets. Testing results showed that using at least two indications of frailty on multiple dates of service to specify frailty is more specific and may better identify those who are frail. For Measurement Year 2023, NCQA updated those measures that include the frailty exclusion to specify that at least two indications of frailty with different dates of service are required. NCQA saw only minor impacts on denominator size during testing and does not anticipate denominator increases resulting from the specification changes to be substantive. Furthermore, we expect any such increase to uniformly affect all organizations.