

Integrated Healthcare Association
Align. Measure. Perform. (AMP) Programs

Audit Review Guidelines
Measurement Year 2018

Released November 2018



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Introduction

Introduction

Background

The clinical quality measures can be found in the *Integrated Healthcare Association California Align. Measure. Perform. (AMP) Programs: Measurement Year 2018 AMP Manual* and should be used with this document. Many of the clinical measures are adapted from the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), the most widely used set of performance measures in the United States. NCQA is a not-for-profit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

AMP also includes an audit review to ensure that results are an accurate report of Physician Organization (PO) performance. The audit review of the clinical measures is based on NCQA's HEDIS Compliance Audit™ program. NCQA staff have worked with **AMP** participants since 2003 to incorporate the relevant components of the HEDIS Compliance Audit and to adapt policies and procedures where necessary.

Because this program is an adaptation, it is not considered a HEDIS Compliance Audit, but an **Align. Measure. Perform. (AMP) Audit Review**. This manual includes the information needed to collect, report and conduct an audit review of the clinical measures included for the **AMP** reporting initiative.

Contents of This Manual

Audit Review for Health Plans	This section contains information on additions to the audit process for health plans reporting AMP data on behalf of POs.
AMP Audit Standards for POs	This section includes the HEDIS Compliance Audit Standards that apply to the AMP data.
Audit Review for POs	This section includes all components of the audit review for POs, including an overview, audit standards and a detailed description of the audit review process.
Appendices	These sections contain AMP PO audit review documents, including the PO Record of Administration, Data Management, and Processes (Roadmap), a data source documentation checklist, decision point grid, IS standards compliance tool and a glossary.

What's New in This Manual

- New language is in **red font** in the e-version.
- Updated the program's name from Value Based Pay for Performance (VBP4P) to Align. Measure. Perform., or AMP, throughout the entire manual.
- Redesigned the Roadmap and IS Standards by consolidating, removing and adding questions and revising document requests to enhance the audit process.
- Removed references to the Roadmap Attestation and replaced with Management Representation Letter. Added language to explain the Management Representation Letter.
- Updated the Audit Timeline.

If You Have Questions About the AMP Programs

Technical Support

NCQA provides different types of policy support to customers, a function that allows customers to submit specific policy interpretation questions to NCQA staff: The Policy Clarification System (PCS) system. The PCS system can be accessed through the NCQA website at <http://my.ncqa.org>.

- Step 1** Use the following link: my.ncqa.org
- Step 2** If you don't have an account, create one.
- Step 3** After logging in, click the **My Questions** button and then **Ask a Question** button.
- Select **PCS (Policy/Program Clarification Support)**.
 - For *Product/Program Type*, click **IHA – AMP programs** in the drop-down box.
 - For *General Content Area*, select the appropriate category for your question.
 - For *Specific Area*, scroll down and click the appropriate area, or click **Not Applicable** if your question type is not listed.
 - For *Publication Year*, click **2019 (for MY2018)** from the drop-down box.
 - For *Subject*, type the subject of your question.
 - For *Question*, type your question (3,000 characters or less).
- Step 4** Click **Submit Your Question**.

FAQs and Policy Updates

FAQs are posted on the IHA website (www.iha.org).

Reporting Hotline for Fraud and Misconduct

NCQA does not tolerate submission of fraudulent, misleading or improper information by organizations as part of their survey process or for any NCQA program.

NCQA has created a confidential and anonymous Reporting Hotline to provide a secure method for reporting perceived fraud or misconduct, including submission of falsified documents or fraudulent information to NCQA that could affect NCQA-related operations (including, but not limited to, the survey process, the HEDIS measures and determination of NCQA status and level).

How to Report

- **Toll-Free Telephone:**
 - English-speaking USA and Canada: **844-440-0077** (not available from Mexico).
 - Spanish-speaking North America: **800-216-1288** (from Mexico, user must dial 001-800-216-1288).
- **Website:** <https://www.lighthouse-services.com/ncqa>
- **Email:** reports@lighthouse-services.com (must include NCQA's name with the report).
- **Fax:** 215-689-3885 (must include NCQA's name with the report).

AMP Audit Review for Health Plans

Modifications to the Health Plan HEDIS Compliance Audit

Enrollment in the PO	The Certified Auditor confirms that the health plan appropriately calculated enrollment at the PO level, as specified in the <i>AMP General Guidelines</i> . As part of this process, the auditor assesses whether the health plan accurately maintains associations between the member and the PO.
Medical record data	The Certified Auditor confirms that medical record review was not used to collect AMP data.
Roadmap completion	The audit begins when a PO completes the current Record of Administration, Data Management and Processes (Roadmap). The Certified Auditor may request additional detailed information about the processes for generating measure results by PO. Electronic copies of the Roadmap are available from your NCQA Licensed Organizations each November.
Core set selection	If the health plan does not use a vendor with NCQA Certified Measures, the Certified Auditor selects a core set of measures for detailed source code review. Selection is based on many considerations, including, but not limited to , the initial assessment of the Roadmap and a review of the previous year's results.
Source code review	The source code review is a manual or automated process of examining programming to verify that it is accurate and complete, and that it complies with measure specifications.
Supplemental data	<p>Refer to <i>Supplemental Data Validation</i> in the <i>AMP Audit for PO Review</i> section of this manual for details on validating supplemental data.</p> <p>AMP health plans that use audited PO supplemental data receive the audited data files, audit results and primary source verification (PSV) samples from the PO by the April deadline. The health plan receives all supporting documents for each supplemental data source (e.g., Roadmap section, file layouts, training materials) when the Roadmap is submitted to the auditor (<i>by January 31 or at least two weeks prior to the site visit, whichever date is earlier</i>). The PO sends the health plan all necessary documentation to support the use of supplemental data.</p> <p>Only health plans that participate in the AMP program may use audited PO supplemental data for their AMP and HEDIS data submissions. The PO provides the health plan with a completed Roadmap section for each supplemental data source, all applicable attachments, the auditor's review findings and PSV results.</p> <p>Note: AMP health plans are not required to collect proof-of-service documents for these audited and approved PO data.</p>
Benchmarks and thresholds	<p>The Certified Auditor validates the reasonability of the PO data reported by the AMP health plans by:</p> <ul style="list-style-type: none"> • At a minimum, comparing PO rates reported in the current reporting year with rates reported in prior AMP reporting year. • Comparing mean PO rates with the plan's HEDIS administrative rates.

Other data checks

- General**
- Compare the ENRST denominator to total group enrollment for similarity.
 - Check the PO master list to ensure that all groups are reported.
 - Ensure that the rate column equals the numerator column/denominator column.
 - Ensure that each rate field has five digits after each decimal and that numbers have not been rounded.
 - Ensure that no rate is more than 100%.
 - Compare **AMP** total enrollment to the total plan enrollment.
 - Check each **AMP** ID/Sub ID file:
 - For a record for each clinical measure.
 - For ENRST.
- Measure-specific**
- *Chlamydia Screening in Women*: Ensure that the sum of the denominators and numerators of each age group is the total for the overall age group.
 - Ensure that the denominator for Diabetes Care is the same for all reported numerators.
 - Ensure that the sum of all PO denominators for a specific measure equals or is less than the health plan’s HEDIS eligible member population.
- Compare the following rates**
- The **AMP** current rate with the HEDIS current rate.
 - The **AMP** current rate with the **AMP** rate in the prior year.
 - The **AMP** current rate with the **AMP** NCQA plan-level percentiles and thresholds.
 - *For new measures*, the **AMP** current rate with the prior year’s HEDIS administrative rate.
- Audit results**
- The **AMP** Audit Review results in audited rates or calculations at the measure level and indicate if the measures can be publicly reported. All measures selected for reporting must have a final, audited result. A measure selected for reporting by a PO can receive a rate of *BR* if the auditor determines it is materially biased, or *NR* if it is not reportable.

For AMP MY 2018 Measures Only

Health plan results Health plan audits assess each contracted PO, indicating each measure’s suitability for data aggregation. The auditor gives a designation for the rate of each measure included in the audit, as shown in the table below.

Rate/Result	Comment
0–XXX	<i>Reportable.</i> Reportable rate for AMP measure. The rate of 0 includes instances when the health plan calculated the rate but found that no members met the criteria specified in the denominator.
<i>BR</i>	<i>Biased Rate.</i> The calculated rate was materially biased. The auditor determines a result is not reportable due to material bias.
<i>NR</i>	<i>Not Reported.</i> The health plan did not report the measure (may only be used only for testing measures).
<i>NB</i>	<i>No Benefit.</i> The health plan did not offer the health benefit required by the measure (e.g., pharmacy).

Note

- For measures reported as a rate, **materially biased** is any error that causes a (+/-) 5 percentage point difference in the reported rate.
- Testing measures do not require an audit result. These measures are collected but not audited.

Data submission

The final date for audited AMP data submission to NCQA's subcontractor, TransUnion HealthCare, is shown on the "Data Collection and Reporting Timeline" in the AMP General Guidelines. The timeline also shows the date when TransUnion HealthCare provides the standard format for submitting data.

The auditor approves the health plan's data submission file to TransUnion HealthCare, including all data elements defined in the data submission file specifications.

Final Audit Opinion

At the close of the audit, the auditor renders the Final Audit Opinion, which contains an audit review statement for AMP data. The Final Audit Opinion for AMP must be submitted to NCQA no later than 30 days after the HEDIS commercial reporting deadline.

Final Audit Report

When the audit is complete, the auditor prepares a Final AMP Audit Review Report, which includes the summary report, the IS assessment and findings for all POs. The auditor submits copies of the report to the organization and to NCQA, which uses it to evaluate the audit process and to ensure that all audits are conducted according to guidelines.

The report must provide enough information for NCQA to evaluate the rates and audit results and decide if the rates and audit results are supported by the work performed. The Final Audit Opinion for AMP must be submitted to NCQA no later than 30 days after the HEDIS commercial reporting deadline.

Health Plan AMP Audit Review Statement

The template for the Audit Review Statement is below. The auditor submits this document electronically to the audit department at NCQA. There is only one Audit Review Statement for all AMP PO-level data the plan provides.

Health Plan **AMP** Audit Review Statement

We have examined **MY 2018** submitted measures of **[insert health plan’s name here]** for conformity with the Integrated Healthcare Association **Align. Measure. Perform. Programs: AMP MY 2018** Clinical Measure Specifications and the **AMP MY 2018** Audit Review Guidelines. Our audit planning and testing were constructed to measure conformance to the **AMP MY 2018** Manual (health plan sections only) for all measures presented at the time of our audit.

This report is the **[insert health plan’s name here]** management’s responsibility. Our responsibility is to express an opinion on the report based on our examination pursuant to the audit guidelines established in the **MY 2018 AMP** Manual. Our examination included procedures necessary to obtain reasonable assurance that the **MY 2018** submitted measures were generated according to the **AMP MY 2018** Manual and, accordingly, included procedures we considered necessary to obtain a reasonable basis for rendering our opinion. Our opinion does not constitute a warranty or any other form of assurance as to the nature or quality of the health services provided by or arranged by any of the participating Provider Organizations (PO), the adequacy of the PO information systems, or the PO policies and procedures for submission of data to the health plan.

In our opinion, **MY 2018** submitted measures of **[insert health plan’s name here]** were prepared according to the **AMP MY 2018** Manual and presents fairly, in all material respects, the Health Plan’s adherence to these specifications.

We understand that if the signatures we submit below are electronic, they have the same legal effect, validity and enforceability as original signatures submitted on paper.

(NCQA-Certified Auditor) _____
(Date)

(Responsible Officer) _____
(Date)

Organization ID: _____

Submission ID(s): _____

Audit review work papers

In addition to the Final Audit Report submitted to NCQA, Certified HEDIS Compliance Auditors (CHCA) retain additional work papers related to the **AMP** audit review and make them available on request for monitoring purposes. Work papers include all relevant documentation completed, requested or reviewed during the **AMP** audit review. NCQA requires audit documentation and work papers to be retained for seven years after the reporting deadline.

The NCQA monitoring program includes a review of these papers and ensures adherence to program policies and procedures. All email and phone log correspondence between team members, the auditor and the PO must be available during monitoring.

For a complete list of required documents, refer to *HEDIS 2019 Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*.

AMP Audit Standards for POs

Overview

AMP Audit Review Standards for POs are derived from NCQA's HEDIS Compliance Audit Standards, the foundation on which Certified HEDIS Compliance Auditors assess a health plan's ability to report HEDIS data accurately and reliably. These standards represent key processes involved in AMP clinical data collection and reporting.

This section includes the standards and assessments that apply to POs that self-report the AMP clinical data, and which are a derived subset of the HEDIS Compliance Audit Standards that health plans must meet during HEDIS audits.

Standards are divided into two sections.

1. **Information System (IS) standards used in AMP Audit Review.** Because AMP clinical data depend on the quality of the PO's information systems, the **IS standards** measure how the PO collects, stores, analyzes and reports medical, service, member and vendor data. A PO unable to process health care data cannot accurately and reliably report AMP clinical information.

The standards specify the minimum requirements that information systems should meet and criteria for manual processes used in AMP clinical data collection. The audit review assesses the IS standards and ensures that the PO has effective systems information practices and control procedures for reporting AMP clinical data.

2. **Measure Determination (HD) standards used in AMP Audit Review.** The **HD standards** are the foundation against which auditors assess AMP clinical data compliance (i.e., if a PO adhered to specifications). The standards describe specific information that the auditor should look for, such as proper identification of denominators and numerators and verifying algorithms and rate calculations.

Auditors must take into account PO compliance with the IS and HD standards to assess AMP reporting capabilities fully. To verify compliance with these standards, NCQA requires that all applicable items be evaluated during an audit engagement.

Information System Standards

IS 1.0 Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry

IS 1.1 Industry standard codes (e.g., ICD-10-CM, ICD-10-PCS, CPT,¹ HCPCS) are used and all characters are captured.

- Data submission documents and transaction files include industry standard codes with full character levels.
- Claims and encounter data entry screens allow entry of all codes and **appropriate** characters.
- Data entry processors enter all codes and characters.
- Policy and procedure manuals document that **all codes and characters** cannot be altered or deleted and that default codes are not used or are mapped correctly **if they are**.

IS 1.2 Principal codes are identified and secondary codes are captured.

- Data submission documents and transaction files differentiate principal codes from secondary codes.
- Claims and encounter data entry screens allow entry of all principal and secondary codes.
- Data entry processors enter all principal and secondary codes accurately.

IS 1.3 Nonstandard coding schemes are fully documented and mapped back to industry standard codes.

- Mapping documents show that all nonstandard codes and code systems are identified and mapped according to the requirements in the General Guidelines.
- Program code ensures that mapping documents are executed accurately.

IS 1.4 Standard submission forms are used and capture all fields relevant to **AMP** measure reporting. All proprietary forms capture equivalent data. Electronic transmission procedures conform to industry standards.

- Standard and nonstandard forms have policies, procedures and completion instructions to verify that all fields relevant to **AMP** reporting are included.
- Nonstandard submission forms include required data and capture all **required**:
 - Codes.
 - Characters for all codes.
 - Data fields listed in the PO Roadmap for the appropriate claims system.
- Electronic file formats are consistent with industry standard forms and capture all data fields **and required codes and characters** listed in the PO Roadmap for the appropriate claims system.
- Policies and procedures for submitting information on electronic forms **ensure**:
 - The PO effectively monitors the quality and accuracy of electronic submissions.
 - Transmissions are properly controlled by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs.

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IS 1.5 Data entry and file processing procedures are timely and accurate and include sufficient edit checks to ensure accurate entry and processing of submitted data in transaction files for AMP measure reporting.

- Claims and encounter data entry screens display:
 - Edit checks for parity, field sizes, date ranges, code ranges.
 - Cross checks with member and practitioner files.
 - All data fields listed in the appropriate claims section of the PO Roadmap.
- Reports for claim/encounter processing staff and hardware operations verify that the PO effectively monitors the quality, accuracy, timeliness and productivity of the entry processes.
- Flowcharts clearly describe claim and encounter processing from all sources.
- Policies and procedures and training manuals for data submission and entry ensure accuracy and completeness.
- Data transaction files confirm accuracy, including:
 - Comparison of a sample of data entry files with source documents to ensure that all data are entered and are not changed or deleted during processing.
 - Capture of denied claims for AMP reporting, if applicable.

IS 1.6 The PO continually assesses data completeness and takes steps to improve performance.

- The PO's data completeness studies help determine their impact on AMP reporting.
- Payment arrangements for all providers show their impact on AMP reporting.
- Policies, procedures and performance standards require complete submission of claims or encounter data from all practitioners to assess data completeness.

IS 1.7 The PO regularly monitors vendor performance against expected performance standards.

- Contracts with vendors confirm that the PO:
 - Requires data for AMP reporting.
 - Provides inspection and onsite auditing of data, correction and resubmission of data.
 - Has backlog control standards and procedures and enforces quality standards.
- Studies and reports are used to:
 - Determine that claim and encounter data from vendors are complete and accurate.
 - Ensure that no data are lost or modified during transfer among vendors.

Measure Certification

The auditor is required to assess compliance with this standard. No item is affected by Measure Certification.

IS 2.0 Enrollment Data—Data Capture, Transfer and Entry

IS 2.1 The PO has procedures for submitting AMP-relevant information for data entry. Electronic transmissions of membership data have necessary procedures to ensure accuracy.

- Policies, procedures, log forms and training manuals for data submission ensure accuracy and completeness and verify that the PO has mechanisms for transferring information to the appropriate location within the PO.
- Forms used by employers for additions, deletions and changes—including samples of completed forms, policies, procedures and instructions for completing membership forms—ensure that all fields relevant to AMP reporting are included.
- Electronic file formats and protocols ensure capture of all data fields listed in the PO Roadmap.
- Policies and procedures for submitting and transmitting electronic information should include evidence that:
 - The PO effectively monitors the quality and accuracy of its electronic submissions.
 - Transmissions are properly controlled by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs.

IS 2.2 Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.

- Standard monitoring reports for all membership operations personnel—including data entry, membership processing staff and hardware operations—verify that the PO effectively monitors the quality, accuracy, timeliness and productivity of its entry processes.
- Flowcharts describe membership processing from all sources.
- Data entry processors enter all required AMP data elements.
- Data entry policies and procedures and training manuals ensure accuracy and completeness.
- Membership data entry screens have:
 - Proper edit checks for parity, field sizes, date ranges, code ranges, practitioner services by specialty and cross checks with member and practitioner files.
 - All data fields listed in the PO Roadmap.
- Data transaction files are accurate, including:
 - Comparison of a sample of data-entry files with source documents to ensure that all data are entered and are not changed or deleted during processing.
 - Comparison of a sample of electronically transmitted files with source documents to ensure that all data are transmitted and are not changed or deleted during processing.

IS 2.3 The PO continually assesses data completeness and takes steps to improve performance.

- The PO's membership system can accommodate:
 - Changes in family status.
 - Changes in employment.
 - Changes in product line.
 - Changes in product.
 - Methods for defining coverage start and end.
 - Multiple membership status changes, including membership periods and disenrollment information.

- Policies, procedures and performance standards require:
 - Complete submission and entry of membership data.
 - Proper control of transmissions through logs, record count verification, redundancy checking receipts, retransmissions and sign-offs.
- Policies, procedures and performance standards:
 - Require complete submission of data to ancillary vendors.
 - Describe the process for submitting data to ancillary vendors and how often data are submitted.
 - Describe the data oversight process for the ancillary vendor.

IS 2.4 The PO regularly monitors vendor performance against expected performance standards.

- Contracts with vendors require data for AMP reporting and provide inspection and onsite auditing of data; correction and resubmission of data and backlog control standards and procedures; and enforce quality standards.
- Studies and reports show that:
 - Membership level data from or sent to vendors are complete and accurate.
 - No data are lost or modified during transfer.

Measure Certification

The auditor is required to assess compliance with this standard. No item is affected by Measure Certification.

IS 3.0 Practitioner Data—Data Capture, Transfer and Entry

IS 3.1 Provider specialties are fully documented and mapped to AMP provider specialties necessary for measure reporting.

- Mapping documents show that all providers are identified and mapped according to the requirements in the specifications.
- Program code ensures that mapping documents are executed accurately.
- Review ensures that facilities are not mapped to provider types unless the organization can demonstrate that all providers rendering services at the facility meet the NCQA definition of “provider” (Appendix 3).

IS 3.2 The organization has effective procedures for submitting AMP measure-relevant information for data entry. Electronic transmissions of practitioner data are checked to ensure accuracy.

- Policies, procedures, log forms and training manuals for data submission ensure accuracy and completeness and verify that the organization has mechanisms for transferring information to the appropriate location within the organization.
- Forms used to process practitioner additions, deletions and changes—including samples of completed forms, policies, procedures and instructions for completing the forms—ensure that all fields relevant to AMP reporting are included.
- Electronic file formats and protocols ensure capture of all data fields.
- Policies and procedures for submission and transmission of electronic information ensure:
 - The organization effectively monitors the quality and accuracy of its electronic submissions.
 - Transmissions are properly controlled by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs.

IS 3.3 Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.

- Standard monitoring reports for all provider operations personnel—including data entry, provider processing staff and hardware operations—verify that the organization effectively monitors the quality, accuracy, timeliness and productivity of its entry processes.
- Flowcharts describe provider processing from all sources.
- Data entry processors enter all required AMP data elements in the claims processing system.
- Data entry policies and procedures and training manuals ensure accuracy and completeness.
- Provider claims processing screens have:
 - Proper edit checks for parity checks, field sizes, date ranges, cross checks with claims/ encounter and practitioner file, code ranges and practitioner services by specialty.
 - All data fields listed in the PO Roadmap.
- Data transaction files are accurate, including:
 - Comparison of a sample of data entry files with source documents to ensure that all data are entered and that data are not changed or deleted during processing.
 - Comparison of a sample of electronically transmitted files with source documents to ensure that all data are transmitted and that data are not changed or deleted during processing.

IS 3.4 The organization continually assesses data completeness and takes steps to improve performance.

- Policies, procedures and performance standards require:
 - Complete submission and entry of provider data.
 - Proper control of transmissions through logs, record count verification, redundancy checking receipts, retransmissions and sign-offs.

IS 3.5 The organization regularly monitors vendor performance against expected performance standards.

- Contracts with vendors require data for AMP reporting and provide inspection and onsite auditing of data; correction and resubmission of data and backlog control standards and procedures; and enforce quality standards.
- Studies and reports show that:
 - Practitioner-level data from vendors are complete and accurate.
 - No data are lost or modified during transfer.

Measure Certification

The auditor is required to assess compliance with this standard. No item is affected by Measure Certification.

IS 4.0 Supplemental Data—Capture, Transfer and Entry

IS 4.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes.

- Mapping documents show that all nonstandard codes and code systems are identified and mapped according to the requirements in the *General Guidelines*.
- Program code ensures that mapping documents are executed accurately.

IS 4.2 The PO has effective procedures for submitting AMP measure-relevant information for data entry. Electronic transmissions of data have checking procedures to ensure accuracy.

- Policies, procedures, log forms and training manuals for data submission ensure accuracy and completeness and verify that the PO has mechanisms for transferring information to the appropriate location within the PO.
- Forms—including samples of completed forms, policies, procedures and instructions for completing the forms—ensure that all fields relevant to AMP reporting are included.
- Electronic file formats and protocols ensure capture of all data fields listed in the PO Roadmap.
- Policies and procedures for collecting supplemental data specify:
 - Exclusions are not collected for previous reporting years for members with clinical conditions that can change.
 - Information obtained by the provider's office or clinician directly from the member is entered in the medical record by the deadline established for the measure.
 - Information obtained by the provider's office or clinician directly from the member is verified when taking a patient history.
 - Information obtained from a simple provider attestation is not used.
 - Information obtained from member surveys is not used.
 - Proof-of-service documentation is collected for all member-reported data.
- Policies and procedures for submission and transmission of electronic information:
 - The PO effectively monitors the quality and accuracy of its electronic submissions.
 - Transmissions are properly controlled by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs.

IS 4.3 Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.

- Standard monitoring reports for all personnel—including data entry, provider processing staff and hardware operations—verify that the PO effectively monitors the quality, accuracy, timeliness and productivity of its entry processes.
- Flowcharts describe data from all sources.
- Data entry processors enter all required AMP data elements.
- Policies and procedures and training manuals for data entry ensure accuracy and completeness.
- Data entry screens have:
 - Proper edit checks for parity checks, field sizes, date ranges, cross checks with claim/ encounter and practitioner files, code ranges and practitioner services by specialty.
 - All data fields listed in PO Roadmap.

- Data transaction files are checked for accuracy, including:
 - Comparison of a sample of data entry files with source documents to ensure that all data are entered and are not changed or deleted during processing.
 - Comparison of a sample of electronically transmitted files with source documents to ensure that all data are transmitted and are not changed or deleted during processing.

IS 4.4 The PO continually assesses data completeness and takes steps to improve performance.

- Policies, procedures and performance standards require:
 - Complete submission and entry of data.
 - Proper control of transmissions by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs to ensure that all data are received.
- Contracts with vendors require data for AMP reporting and provide inspection and onsite auditing of data, correction and resubmission of data and backlog control standards and procedures.
- Policies, procedures and performance standards require reconciliation of data between the originating system and the repository.

IS 4.5 The PO regularly monitors vendor performance against expected performance standards.

- Documentation acquired by the PO shows that the responsible agency has reasonable processes in place for data collection and accuracy.
- Studies and reports show that:
 - Data from vendors are complete and accurate.
 - No data are lost or modified during transfer.

Measure Certification

The auditor is required to assess compliance with this standard. No item is affected by Measure Certification.

IS 5.0 Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

IS 5.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented.

- Mapping documents show that code systems are identified and mapped according to the requirements in the specifications.
- Program code ensures that mapping documents are executed accurately.

IS 5.2 Data transfers to AMP repository from transaction files are accurate.

- Standard monitoring reports for all operations personnel, including IS staff and hardware operations, verify the organization effectively monitors the quality and accuracy of its processes.
- Flowcharts describe data from all sources.
- Data source identifiers are clear and documented.
- Repository data entry and data transfer processes produce the intended result.
- Policies and procedures document building, maintaining, testing and reporting for the reporting repository.
- Data samples from transaction files and medical record abstraction are compared with the repository to ensure accurate procedures for populating the repository.
- Repository edit lists explain all edit failures.
- Electronic file formats and protocols ensure capture of all data fields.
- Policies and procedures for submission and transmission of electronic information show:
 - The organization effectively monitors the quality and accuracy of its electronic submissions.
 - Transmissions are properly controlled by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs.
- Training materials and procedure manuals for operator staff ensure accuracy and completeness.

IS 5.3 File consolidations, extracts and derivations are accurate.

- Repository data manipulation programs and processes produce the intended result, including programs that consolidate information from multiple transaction files.
- Flowcharts describe data from all sources.
- Data source identifiers are clear and documented.
- Mechanisms link data across all data sources to satisfy measure data integration requirements.
- Data entry screens show all data are captured.

IS 5.4 Repository structure and formatting is suitable for measures and enable required programming efforts.

- The repository design ensures it can accommodate analysis that produces measure results. Documents available for review include:
 - Record and file formats.
 - Descriptions for entry and intermediate files.
 - Data source identifiers are clear and documented.

IS 5.5 Report production is managed effectively and operators perform appropriately.

- Policies, procedures and dated job logs govern the production process.
- Report run controls are reviewed by operators.

IS 5.6 The organization regularly monitors vendor performance against expected performance standards.

- Contracts with vendors require data for reporting and provide inspection and onsite auditing of data; correction and resubmission of data; and enforcement of quality standards.
- Studies and reports show that:
 - Data and results from vendors are complete and accurate.
 - No data are lost or modified during transfer.

Measure Certification

The auditor is required to assess compliance with this standard. No item is affected by Measure Certification. If the measure vendor maintains a repository and documents describing the repository structure, they should be included with the Roadmap.

IS 6.0 Data Integration and Reporting—Accurate AMP Reporting, Control Procedures That Support AMP Reporting Integrity

IS 6.1 Data transfers to AMP measure vendor repository from AMP repository are accurate.

- Standard monitoring reports for all operations personnel, including IS staff, and hardware operations verify that the PO effectively monitors the quality and accuracy of its processes.
- Flowcharts describe data from all sources.
- Data source identifiers are clear and documented.
- AMP repository data entry and data transfer processes produce the intended result.
- Policies and procedures document building, maintaining, testing and reporting for the AMP reporting repository.
- Data samples from transaction files are compared with the AMP repository to ensure accurate procedures for populating the repository.
- AMP repository edits lists explain all edit failures.
- Electronic file formats and protocols ensure capture of all data fields.
- Policies and procedures for submission and transmission of electronic information show:
 - The PO effectively monitors the quality and accuracy of its electronic submissions.
 - Transmissions are properly controlled by logs, record count verification, redundancy checking receipts, retransmissions and sign-offs.
- Training materials and procedure manuals for operator staff ensure accuracy and completeness.

IS 6.2 Report production is managed effectively and operators perform appropriately.

- Policies, procedures and dated job logs govern the production process.
- Report run controls are reviewed by operators.

IS 6.3 AMP measure reporting software is managed properly with regard to development, methodology, documentation, version control and testing.

- AMP repository manuals cover the application system development methodology, database development and design, and the decision support system used to validate proper controls.
- Report documentation, including code review methodology and testing, meets industry standards.
- Programming specifications, work flow diagrams, data sources and diagrams or narrative descriptions meet industry standards.
- A list of measures indicates the programmer responsible for each measure.

IS 6.4 The organization regularly monitors vendor performance against expected performance standards.

- Contracts with vendors require data for reporting and provide inspection and onsite auditing of data; correction and resubmission of data; and enforcement of quality standards.
- Studies and reports show that:
 - Data and results from vendors are complete and accurate.
 - No data are lost or modified during transfer.

Measure Certification

The transfer of data from the measure repository to the measure vendor is not certified. The measure code is tested as part of the Measure Certification program.

If the PO uses AMP Certified MeasuresSM, this information is included in the **Data Integration and Reporting section** of the PO Roadmap. The PO and auditor must ensure that the appropriate version of the certified measure was used to produce AMP results by reviewing and validating the unique measure identifier (GUID).

Measure Determination Standards

HD 1.0 Denominator Identification

HD 1.1 Members and service events are correctly categorized into member subgroups.

- Code and program flowcharts ensure accurate calculation of:
 - Age.
 - Age range.
 - Gender.
 - Product.
 - Product line.
 - Enrollment determination date.
 - Newborns.
- Member-level files ensure accuracy:
 - Comparison of a sample of member-level files with source documents to ensure that all data are correctly processed.

HD 1.2 Relevant medical and service events are correctly considered in terms of time and services.

- Code and program flowcharts ensure that they:
 - Adhere to the **AMP** time frame requirements for periods of membership.
 - Properly identify events that require linking visit codes, procedure codes and practitioner type codes.
 - Properly identify events that require matching claim/encounter and pharmacy data.
 - Properly identify claim/encounter-dependent events.
 - Use all the correct clinical codes.
 - Include all members in the denominator, whether or not they had services.
 - Include all model types and practitioners in the measures and a correct count.
- Member-level files ensure accuracy:
 - Comparison of a sample of member-level files with source documents to ensure that all data are correctly processed.

HD 1.3 Membership parameters and continuous enrollment are computed as defined by **AMP**.

- Code and program flowcharts ensure that the software:
 - Adheres to the **AMP** time frame requirements for periods of membership.
 - Determines continuous enrollment in the specified period, including any allowable gaps in enrollment followed by reenrollment.
 - Tracks member enrollment history, separate coverage periods, change in ID numbers, change in relationship to subscriber and change in product or product line.
 - Provides a complete and unduplicated count of member months and other membership variables.
 - Properly assigns members to products and product lines for reporting.
- Member-level files ensure accuracy, including:
 - Comparison of a sample of member-level files with source documents to ensure that all data are correctly processed.

Measure Certification

If the PO uses AMP Certified MeasuresSM, the auditor must review and validate the unique measure identifier to ensure that the certified version of the measure was used. The auditor should not review the denominator identification logic for measures with a *Pass* status.

If any measure received a *Fail* status, the auditor must evaluate the process used by the PO or vendor to produce the results. The auditor must review all source code associated with measures not included in the Certification Report.

HD 2.0 Numerator Identification

HD 2.1 Claims or encounter, membership, practitioner and vendor data are analyzed properly in the assessment of numerator qualifications.

- Program code and program flowcharts ensure:
 - Compliance with specified time frames for medical and service events.
 - Accurately computed multiple numerator events.
 - Use of correct clinical codes.
 - Evaluation of correct time periods for numerator events.
- Member-level files ensure accuracy, including:
 - Comparison of a sample of member-level files with source documents to ensure that all data are correctly processed.
- Code and program flowcharts ensure:
 - Identification of specified medical and service events (e.g., diagnoses, procedures, prescriptions, volume of calls).

Measure Certification

If the PO uses **AMP** Certified MeasuresSM, the auditor **must** review and validate the unique measure identifier to ensure that the certified version of the measure was used. The auditor should not review the numerator logic for measures that received a *Pass* status.

If any measure received a *Fail* status, the auditor must evaluate the process used by the PO or vendor to produce a numerator. The auditor must review all source code associated with measures not included in certification.

HD 3.0 Algorithmic Compliance

HD 3.1 Rate calculations are arithmetically correct and precise.

- Code and program flowcharts ensure accurate:
 - Computation of row and column totals.
 - Computation of percentages.

HD 3.2 Rates are accurately entered into the data submission tool.

- Numerator and denominator counts are accurately entered into the submission tool.

Measure Certification

The auditor is required to assess compliance with this standard. No item is affected by Measure Certification.

HD 4.0 Outsourced or Delegated AMP Reporting Function

HD 4.1 If the PO delegates any aspect of AMP data collection or reporting to an external vendor, vendor data meet all applicable NCQA AMP Compliance Audit standards.

- Materials for all previous IS and HD standards ensure that the vendor complies with standards.
- Contracts ensure:
 - Communication of quality standards.
 - Data submission is required on a timeline consistent with AMP reporting.

HD 4.2 The PO regularly monitors vendor performance against expected performance standards.

- Studies and reports:
 - Determine if the PO reviews vendor performance against quality and timeliness standards.
 - Ensure that no data are lost or modified during transfer among vendors.
 - Ensure that vendor errors and deficiencies are addressed completely and in a timely manner.

HD 4.3 If aspects of AMP data collection or reporting are delegated to multiple vendors, the PO coordinates vendor activities to safeguard the integrity of AMP data.

- Flowcharts determine if the data flow among vendors will impede accuracy or timeliness of the AMP report.

HD 4.4 The PO works with the vendor to get preliminary and final rates according to the audit timeline.

Measure Certification

The auditor is required to assess compliance with this standard. No item is affected by Measure Certification.

AMP Audit Review for POs

Policies and Procedures

Who Must Undergo an Audit Review?

Any organization that produces AMP data must undergo a AMP Audit Review. Licensed Organizations contracting with a health plan or PO ensure that NCQA's requirements are met. Health plan and PO requirements and responsibilities are listed in *Integrated Healthcare Association California Align. Measure. Perform. Programs: AMP 2018 Measurement Year Manual*.

Licensed Organization and Certified Auditor Qualifications

NCQA has a licensing program for organizations interested in conducting HEDIS Audits and a certification program for individual auditors. NCQA posts lists of Licensed Organizations and Certified Auditors on its website under **HEDIS Compliance Audit Certification**.

Audit Monitoring and Oversight

To ensure the continued success of the audit program, NCQA administers a monitoring program that gives constructive feedback to Licensed Organizations and Certified Auditors to help improve and evolve their practices.

Program goals

- Ensure that audits are conducted in a manner consistent with NCQA specifications, standards and policies and procedures.
- Ensure that the rigor of audits **are** consistent across all Licensed Organizations and Certified Auditors.
- Identify opportunities for improvement (design and implementation).

Performance categories:

NCQA evaluates the consistency of audit practices across organizations and auditors by observing individual Certified Auditors as they conduct Audits at health plans and POs and reviewing work papers for evidence that audits conform with NCQA methodology and documentation standards. NCQA assesses performance by Certified Auditors and Licensed Organizations in five major categories.

- 1. Pre-Audit** Audit strategy, team selection, preparation and initial assessment.
- 2. IS Assessment** Evaluation of systems and processes used to collect and report AMP measures.
- 3. Measure Compliance and Preliminary Rate Review** Determination of compliance with AMP technical specifications and evaluation of preliminary rates.
- 4. Reporting** Conclude audit findings and final rate review for rendering a final audit opinion.
- 5. Work Papers** Documentation and evidence that support the audit activity and decisions in four major areas: offsite, onsite, post-onsite and overall audit effectiveness.

Monitoring results

NCQA focuses on:

- Client communication.
- Roadmap assessment.
- Core set selection and source code review strategies (when appropriate).
- Information systems assessment.
- **AMP** determination evaluation.
- Documentation of issues and resolution.
- Follow-up documentation.
- Submission tool validation.
- Final Audit Reports.

Licensed Organizations receive an annual monitoring report from NCQA that identifies **both** areas of achievement and areas for improvement. **Licensed Organizations** are required to submit a Corrective Action Plan (CAP) to NCQA for all identified areas of improvement.

NCQA may also monitor the quality and satisfaction of the Audit Program through a survey provided to audited health plans and POs after each reporting cycle. Organizations rate their Licensed Organization on various aspects of the audit process, and the findings are used in ongoing evaluation of Licensed Organizations and audit standards and guidelines. NCQA also reserves the right to accompany auditors on audits, to observe their work.

Portability of Opinion

A complete and accurate audit is critical to the integrity of a AMP measure rate. Because an auditor must evaluate the final rate based on every step of the process leading to the rate, NCQA allows only a final audited measure rate rendered by one Licensed Organization to be used in another Licensed Organization's opinion without further review.

NCQA does not allow the portability of audit opinions at the process level (i.e., IS review); therefore, one Licensed Organization's assessment of vendor information systems is not transferable to another Licensed Organization. **Only a final rate is portable and is allowed to be used by another organization.**

Confidential communication

Communications other than the PO's data submission file and the Certified Auditor's Final Audit Report to NCQA are confidential and are known only by the PO and the Certified Auditor. The auditor's working papers are the property of the Licensed Organization and are subject to review by NCQA under the Audit Monitoring Program. NCQA may disclose additional information to third parties if it determines that the PO misrepresented Audit Review results.

Disclaimer

NCQA bears no responsibility for any use by third parties of the Final Audit Report or other information concerning the PO released as provided herein, or for any effect of such release on the PO.

Audit Appeal and Grievance Procedures

Licensed Organization's responsibility

The Licensed Organization has an appeal process that gives organizations the opportunity to file a complaint or appeal an audit result it has issued by the Licensed Organization. The written appeal process is submitted to NCQA for approval as a condition of licensure, and the Licensed Organization conducts all appeals in compliance with the approved appeal process. Any changes to the appeal process must be approved in advance by NCQA.

The Licensed Organization informs the audit client that changes in rates resulting from an appeal may not be eligible for resubmission to NCQA for inclusion in NCQA's reporting products or accreditation, due to publication timelines and other submission deadlines set by third-party stakeholders, including CMS.

The Licensed Organization notifies the NCQA director of Measure Validation, in writing, within two business days of the filing of:

- A complaint against the Licensed Organization.
- A complaint against an auditor employed or directly contracted by the Licensed Organization to perform audits.
- An appealed measure result.

The Licensed Organization investigates and responds within 14 calendar days of filing. It informs NCQA of the investigation's progress and notifies NCQA of the outcome and the nature of any corrective action.

NCQA may investigate a grievance filed with NCQA regarding the actions of the Licensed Organization or a Certified Auditor. The Licensed Organization agrees to cooperate fully in any investigation by NCQA and to institute corrective actions deemed necessary resulting from an investigation. A substantiated grievance may result in termination of the organization's license or the auditor's certification.

Measure Certification

POs and health plans that self-report clinical measures may find value in using a vendor whose measures are certified by NCQA.

If the PO or health plan uses AMP Certified MeasuresSM, the auditor reviews source code only for measures that are not certified. **A full list of measures in the scope of AMP Measure Certification can be found in Appendix 4.** If the PO or health plan reports testing measures, it has the option of including the measures in the audit process.

If the PO or health plan does not use AMP Certified Measures, the auditor reviews source code for a core set of AMP measures. The core set should include, or be augmented to include, measures that represent AMP reporting. In addition, the auditor reviews all additional steps, especially the attribution of results to individual POs and workarounds used to generate the AMP measures.

The Certified Auditor must review each vendor's certification report and determine that the unique identifier on the report matches the unique identifier loaded into the AMP data submissions files for each measure.

Vendors who will participate in the MY 2018 measure certification testing process are listed on the NCQA website (<https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/measure-certification/>). The deadline for vendors to complete AMP measure certification is March 1, 2019.

Advertising

Following completion of an audit, the PO may use the NCQA audit seal to market itself as having completed a NCQA Audit Review. Refer to the *Advertising and Marketing* section in the *AMP Integrated Healthcare Association California Pay for Performance Programs: 2018 Measurement Year Manual*.

Revisions to Policies and Procedures

At its sole discretion, NCQA may amend its *Policies and Procedures*, appeal and grievance procedures or any other audit program policy.

The Audit Process

The AMP Audit Review process includes all parts of the HEDIS Compliance Audit that are relevant to POs reporting AMP clinical data. There are three key parts to the audit review; each is described in detail in the following sections.

- **Offsite Process:**
 - Contract Execution.
 - Roadmap Assessment.
 - Core Set Selection.
 - Manual Source Code Review.
 - Supplemental Data Validation.
 - Site Visit Planning and Kick-Off Calls.
- **Onsite Process:**
 - Onsite Visit.
 - Follow-Up Documents.
- **Post Onsite and Reporting:**
 - Documents and Corrective Actions.
 - Audit Results.
 - Data Submission.
 - **Management Representation Letter.**
 - Final Audit Report.

The Offsite Process

During a **AMP** Audit Review, many tasks are completed away from the PO's location. The audit preparation phase includes all activities that occur before the onsite visit, such as contracting with a Licensed Organization, negotiating a timeline, reviewing the PO Roadmap and planning the onsite visit. Other offsite tasks include core set selection, source code review and supplemental data validation. The sections in this chapter follow the same order as typical audit's offsite activities:

- Contract Execution.
- Roadmap Assessment.
- Core Set Selection.
- Manual Source Code Review.
- Site Visit Planning and Kick-Off Calls.
- Supplemental Data Validation.

Contract Execution

Select an NCQA-Licensed Audit Organization

The first activity in audit preparation is contract execution. This phase includes executing the contract with all the necessary ancillary agreements (e.g., HIPAA business associate agreements, confidentiality and conflict of interest documents) and negotiating a timeline. The organization selects and contracts with an NCQA Licensed Organization to conduct the audit. All Licensed Organizations employ or contract with Certified Auditors and select an audit team for the organization. NCQA lists Licensed Organizations on its website (www.ncqa.org).

Note: NCQA recommends that the contract and all ancillary agreements be executed by **October** of the measurement year.

Negotiate a timeline

During the contracting phase, the PO and the Licensed Organization negotiate an audit timeline. To guide this negotiation, NCQA has set completion dates for several audit milestones that have firm deadlines.

Note: If milestones such as the Roadmap receipt date, the supplemental data stop date or data submission deadlines are missed, the organization might not have sufficient time to respond to the auditor's requested corrective actions, and measures could be at risk for not being reportable. Auditors should work carefully with key staff members, including organization executives, if milestone events are not met.

Activity or Milestone	PO Deadline	Health Plan Deadline
PO contracts with an NCQA-Licensed Organization.	October 1, 2018	
PO submits the completed current year's Roadmap to the auditor. <i>*The auditor must receive the Roadmap by January 31 or at least two weeks prior to the site visit, whichever date is earlier.</i>	January 15–31, 2019*	
Auditor selects a core set of noncertified measures for code review.	February 1, 2019	
Organization submits completed source code for auditor review (for noncertified code).	March 1, 2019	
Supplemental Data Collection Deadline. Organization completes and stops all nonstandard and member-reported supplemental data collection and entry. <i>No exceptions! Failure to meet this deadline could result in inability to use supplemental data to report rates.</i>	February 15, 2019	March 1, 2019
Supplemental Data Validation Deadline. Auditor finalizes approval of <i>all</i> supplemental data for POs. Primary Source Verification (PSV) for nonstandard and member-reported supplemental data must not occur prior to February 15, unless the PO finished all supplemental data processes, collection and entry. <i>There are no exceptions!</i>	March 15, 2019	
Supplemental Data Validation Deadline. Auditor finalizes approval of <i>all</i> supplemental data for health plans . Primary Source Verification (PSV) for nonstandard and member-reported supplemental data must not occur prior to March 1 unless the health plan finished all supplemental data processes, collection and entry. <i>No exceptions!</i>		March 29, 2019
Supplemental Data to Health Plans: AMP health plans receive the audited supplemental data files and audit results from the PO.	March 29, 2019	
<i>Preliminary rate review feedback completed. This date is the latest when this review should be completed. NCQA encourages preliminary rate review to take place earlier in the audit process.</i>	April 12, 2019	
Onsite visits completed.	April 30, 2019	
Submission Files to Auditors: Self-reporting POs and health plans send submission files to auditors.	May 1, 2019	
Auditor Locked AMP Results: Self-reporting POs and health plans submit auditor-locked AMP clinical results to TransUnion HealthCare. Health plans must submit results for all clinical measures for each contracted PO with a signed AMP Consent to Disclosure Agreement. <i>The Management Representation Letter is due.</i>	May 9, 2019	
Questions and Appeals Period: AMP staff works with POs and Health Plans to address any data issues or questions related to quality results. Plans and POs may submit an appeal during this time.	May 24–June 14, 2019	
Appeals Hearing: The AMP Appeals Panel reviews and decides on all appeals to change quality results, if needed.	June 28, 2019	
Resubmission of Auditor-Locked AMP Results: Self-reporting POs and health plans submit auditor-locked AMP clinical results to TransUnion HealthCare, if needed.	July 12, 2019	
Licensed Organizations submit Final Audit Reports to NCQA.	July 15, 2019	

Roadmap Assessment

The PO Roadmap

The Record of Administration, Data Management and Processes (Roadmap) is a comprehensive document auditors use to review information about the PO's systems for collecting and processing data to produce measure reports. The Roadmap also describes the operational and organizational structure of the PO. It includes detailed questions about all audit standards and is used by auditors to plan the onsite visit.

NCQA requires organizations to give the auditor a current year's PO Roadmap every year (the MY 2018 PO Roadmap must be submitted for MY 2018; a copy of the MY 2017 Roadmap is not acceptable). If the PO does not provide the information, the auditor must obtain it.

At the end of the audit process, each organization must sign a management representation letter (an electronic version is acceptable). The letter may be provided to the organization at any point in the audit; however, the organization must complete and sign it and return it to the auditor between May 1 and May 9, after the auditor completes final rate validation. Auditors must maintain the signed copy of this letter in their audit work papers.

The PO Roadmap is the basis for the Certified Auditor's assessment of compliance with audit standards. The auditor uses the PO Roadmap and its supporting documentation for initial assessment. The auditor may not delete any items in the Roadmap, but may include additional questions.

Timing

The auditor uses the completed PO Roadmap to:

- Plan onsite activities.
- Select the core set of measures, if applicable.
- Identify areas that require clarification.

Core Set Measure Selection for Source Code Review

The Certified Auditor examines and approves public reporting for each measure in the organization's report. Because of the large number of measures and the detailed level of assessment, NCQA designed a source code review method for properly selecting a core set of measures as a way to project the findings from the review to the remaining measures.

If the organization uses AMP Certified Measures, the auditor does not select a core set of measures but must review all measures not included in the certification program and any measure that failed certification that the organization intends to report. Measures not included in certification that do not have source code, should be reviewed for proper reporting processes. Refer to Appendix 4 for a list of measures included in the certification program.

The auditor evaluates the information in the Roadmap, the organization's previous measure results and standard programming features to select a set of measures that represent the organization's unique system for measure reporting.

Note: *Selecting the core set is the sole responsibility of the auditor; the organization may not help select the core set.*

The organization supplies the source code and the auditor reviews it for compliance and its impact on measure results. The measures selected for the core set may contain characteristics or programming features common to a group of measures:

- Complex continuous enrollment (CE) criteria.
- Complex code mapping handled in software.
- Identifying exclusions.
- **New measures.**

Although the source code review focuses on programming issues, the auditor may also select measures based on data issues.

Rationales for Core Set Selection

Programming issues

- The organization had programming problems in the previous year.
- Complex programming is required for the measure.
- Complex routines are required for different measure calculations (e.g., CE, member months).
- This is a new measure that should be reviewed.
- This is an existing measure with significant changes.
- This represents all programmers, internal and external.
- This involves hard-coded changes vs. updating a reference table.
- The rate or the denominator is an outlier.
- Changes were made to the report production.
- Product line variations should be reviewed.

Data issues

- The organization receives and incorporates vendor data.
- The Roadmap indicates possible incomplete data.
- Code mapping should be reviewed.
- The organization implemented a system conversion.
- The rate or denominator is an outlier.
- Varied organization demographics should be reviewed.
- Data integration should be reviewed.
- Changes to report production should be reviewed.
- Incentives are offered for measure rate performance.

Additional Core Set Considerations

AMP core set composition

The AMP core set must have a minimum of 9 AMP measures from any domain. If the organization reports fewer than 9 measures, the auditor must review the source code for all AMP measures.

The Certified Auditor works with the organization to determine a schedule for the core set review process.

Core set expansion

Auditor selection of the core set measures is based on the organization's system processes and Roadmap responses. It may be necessary to revise the core set during the onsite visit, when measures that require detailed assessment of organization processes are identified more readily.

The auditor may review additional measures to ensure that findings for related measures are consistent, based on findings during the onsite visit.

Note: The core set may be revised or expanded at any time during the audit.

Manual Source Code Review

Manual source code review is the process of examining original programming to verify that it is accurate and complete and that it complies with the specifications. The Certified Auditor does not have to perform the review, but the reviewer should be proficient in programming languages, knowledgeable about the organizations systems and familiar with measure specifications and guidelines. The audit team is responsible for reviewing and confirming the accuracy of source code for all calculations (denominator, numerator and algorithms) for each measure in the core set.

The following processes may be reviewed for each measure, as shown below with examples of information reviewed.

Processes

- Determine eligible members based on criteria such as age, gender, dates, clinical indicators and membership.
- Examine use of date ranges or date of birth (DOB).
- Identify codes used for gender, usually alpha (M/F) or numeric (0/1).
- Verify specificity of coding, use of proprietary codes and timing.
- Determine if sufficient data are available, and their effect on reporting (e.g., under-reporting the denominator).
- Validate continuous enrollment in the physician organization.
- Determine how family status, plan membership, product line/product or other changes affect membership identification.
- Verify that the system tracks multiple termination and effective dates for members in the PO and for multiple health plans.
- Verify logic used to compare multiple termination and effective dates to determine the length of coverage and length of lapses in coverage.
- Examine the date on which the continuous enrollment period begins.
- Verify membership by product lines/products and by plan.
- Verify members who satisfy the numerator event.
- Verify dates of service by reviewing computer printouts, paper copies of claims/encounters or microfilm.
- Ensure that global fee services are documented with actual dates of service.
- Verify specificity of coding, use of proprietary codes and timing of codes.
- Examine documentation showing that services are actually rendered and not only authorized or prescribed.
- Examine documentation that describes how the measure (or part of the measure) is collected, if calculated by the vendor.

	<ul style="list-style-type: none">• Identify how members are tracked from vendor classifications to PO classifications.
Source code process	<p>To ensure that the reviewer can perform a thorough assessment of source code, the organization provides:</p> <ul style="list-style-type: none">• Flowcharts.• Software documents explaining the programming logic and design.• Input and output file layouts and field descriptions.• Input and output counts.• Run logs. <p>The source code review process can be completed in one of two ways:</p> <ol style="list-style-type: none">1. The Certified Auditor analyzes the code independently, before or after the onsite review, and communicates perceived discrepancies to PO staff.2. The Certified Auditor examines source code with PO staff during the onsite visit. <p>The first approach saves time but may result in more questions if the reviewer does not fully understand the PO's systems. The joint review may be more efficient if it can be completed during the onsite visit.</p> <p>An advantage to code review is that it allows the reviewer to quickly and easily determine if certain tests have not been performed. Verifying that the code properly checks for continuous enrollment may be difficult, but it is easy to ascertain if it tests the proper age range or performs a required gender test. Similarly, exclusions based on clinical codes can be readily determined.</p> <p>Viewing a program sequence does not ensure that the code was executed properly. The examined code may have been bypassed either partially or completely. The auditor ensures that the program was run as specified. One way to test the code is to rerun it against the original files, which requires a file freeze of the AMP clinical data repository. Another way is to run the code against a test file prepared by the auditor, in the format of the expected input file. If the subset is small, the auditor can select a subset of the total file (before the denominator extract) and hand-check the results.</p> <p>An alternative is to prepare a set of data (a test deck) with known results, modify the PO's program to read it and compare program results with expected results.</p>
Decision Point Grid	<p>The auditor completes a Decision Point Grid for each measure to document that measure elements have been checked and verified.</p>
Review results	<p>The source code review can have one of three results:</p> <ol style="list-style-type: none">1. Agreement that the code produces the intended and appropriate output.2. Questions about aspects of the code that require programmer review and possible job reruns.3. Determination that the code is inadequate and must be rewritten before the results can be accepted.

Supplemental Data Validation

Supplemental data validation is an important component of the audit. The auditor confirms that all supplemental data used by the organization for AMP reporting meet audit standards for sound processes and that the data are accurate. The auditor works with the organization to set appropriate interim milestones to ensure supplemental data deadlines are met.

Audit requirements

All supplemental data are subject to annual audit review, and the audit differs only in the degree of review required. There are two distinct categories of supplemental data for the purpose of the audit:

- Standard supplemental data.
- Nonstandard supplemental data.

The auditor conducts separate validations for each source of supplemental data, including reviewing policies, procedures, data file formats and quality control processes.

Only the auditor can determine how to categorize the supplemental data source and is responsible for communicating this to the PO. The auditor must document the rationale for a decision to reclassify previously categorized nonstandard supplemental data source as standard supplemental data.

...for all supplemental data

The auditor reviews Section 4 of the Roadmap to ensure that the provider, agency or other organization responsible for the data has reasonable processes in place for data collection and accuracy. In particular, the auditor confirms that the file layout requires all data elements needed for the measures affected (i.e., date of service, provider identification, diagnosis and service codes). The auditor evaluates the policies and procedures for collecting, managing, mapping, importing and reporting the data.

The organization and the auditor analyze the impact each supplemental data file has on reported AMP rates. Analysis is complete by the May data submission deadline and can be done in a variety of ways, including, but not limited to:

- Review measure rates before and after loading each supplemental data file.
- Comparing of numerator counts for each measure to determine the gain from supplemental data.

...for standard supplemental data

All standard supplemental data are electronic and require minimal intervention to load. Files are in a standard layout with standard codes. No free-text fields are permitted for AMP calculations. Data mapping or data joins (e.g., converting a provider identifier to a specialty code) are clearly documented.

In addition to the tasks for “all supplemental data,” the auditor examines the contents of all standard supplemental data files. Auditors are not required to conduct primary source verification (PSV) to check accuracy and validity of data obtained from standard files but may do so if they assess the need based on a review of documents and process or on other criteria such as preliminary rates.

...for nonstandard and member-reported supplemental data

In addition to the tasks performed for “all supplemental data,” the auditor evaluates the credentials, training and quality control oversight of the organization’s staff who build or maintain nonstandard supplemental data.

The auditor ensures that:

- Training sessions are complete and consistent with measure specifications.
- Forms or tools and instruction materials collect data elements according to the specifications.
- Appropriate staff are collecting data, if measures have a requirement for provider type. This should be validated back to the provider's TIN/NPI. Documentation of NPI/TIN is not required; however, documentation of NPI/TIN along with date, name and signature is preferred.
- Rater-to-standard or interrater reliability quality control testing protocols, standards and reports support reporting.
- Data abstraction tools and instructions meet audit standards.
- Guidance for translating free text to standard codes complies with clinical coding standards and AMP specifications.
- Data entry or uploading processes for adding nonstandard supplemental data to the repository are correct.
 - Additional steps to complete the evaluation are at the auditor's discretion.
- Ensures that data come from acceptable sources.
- Conducts PSV every year, without exception, on all nonstandard files. Validation of nonstandard supplemental data, including PSV, may not be performed before **all** of the following conditions are met, and they must be documented:
 - It is after December 1 of the measurement year.
 - The Roadmap has been submitted (each Section 4 is complete).
 - Supplemental data collection has stopped on or by the deadline*.

PSV requires the following steps:

- The organization finishes collecting the data and closes the files for input.
- The auditor creates a random, systematic or stratified sample using acceptable statistical methods.
 - Random samples may be generated in Excel.
 - Systematic samples may be selected with a skip interval.
 - Stratified samples may be used to ensure that all types of events are included in the sample, when a more random method would likely omit low-volume events.
 - All samples are auditor selected. Although the organization's sample may not be used, any PSV record that overlaps with records in the auditor's sample may be used. *Auditors may share PSV samples, but must validate the samples independently and provide their own results.*
- The auditor gives the list of sampled events to the organization, and the organization submits the proof-of-service (POS) documentation for each event.
- The auditor performs PSV using the POS supplied for each event in the sample and determines:

- That the source of POS is acceptable as described in the AMP Manual. That the POS document was created before January 1 of the reporting year.
- That the POS document contains all the elements required for the measure.
- That the POS document contains appropriate and correct data elements (e.g., dates, procedure, diagnosis, provider information, member information).
- That there were no errors (e.g., mapping strategies were based on standard codes, there were no exclusions for conditions that may change).

POS examples

Proof-of-Service Documents
<ul style="list-style-type: none"> • Laboratory and radiology reports. • Sections of the member's legal health record showing service or assessment. <p>Must be recorded, signed and dated by the rendering provider.</p>

*Refer to the AMP Audit timeline for the current year's date. For some tasks, the requirements differ for POs and health plans.

Sample sizes for nonstandard and member-reported supplemental data

The sample size for nonstandard and member-reported supplemental data validation must be sufficient to assess the accuracy of the information. The sample sizes in the table below are minimums for nonstandard supplemental data files.

Number of Events in File	Minimum Sample Size
0–400	16 events
401–999	5%
≥1,000	50 event

For nonstandard and member-reported supplemental data

The database may not be used if the organization does not give the auditor access to POS documentation for the selected events in a timely manner or if there is no evidence that POS documents were collected for all member-reported supplemental data. Missing POS is counted as an error and no substitutions are permitted. If a PSV critical error is found in two events, the auditor may take one of two actions:

- *If the errors are considered isolated*, request another sample to ensure there are no other instances. If no more errors are found, the samples pass.
- *If the errors are considered pervasive*, permit the organization to demonstrate that the errors can be removed or remedied and request another sample to ensure the corrections were made. If no more errors are found, the samples pass.

If additional review finds one or more errors, the auditor fails the supplemental data source.

If the auditor determines that the supplemental data source is materially biased, the validation fails. Supplemental data that do not pass all audit steps by the deadline may not be used to calculate AMP rates. Organizations may wait to load nonstandard supplemental data until PSV is complete and the source is approved. Work paper documentation lists all validation steps.

Timeline requirements

...for member-reported and nonstandard supplemental data

Data collection stops on or before the required PO or health plan deadline*. The organization works with the auditor to select the sample and approve charts by the deadline*.

...for standard supplemental data

The auditor works with the organization to review and approve these data files by the validation deadline*. **These data sources must be identified and the Roadmap sections completed by the data collection deadline.**

...for PO supplemental data used by AMP health plans

AMP health plans that use audited PO supplemental data receive the audited data files, PSV results and audit results from the PO by the deadline*. The health plan receives all supporting documents for each supplemental data source (e.g., Roadmap section, file layouts, training materials) when the Roadmap is submitted to the auditor (by the deadline*). The PO sends the health plan all necessary documentation to support the use of supplemental data.

*Refer to the **AMP** Audit timeline for the current year's date. For some tasks, the requirements differ for POs and health plans.

Portability of audit findings

Only health plans that participate in the **AMP** program may use audited PO supplemental data for their **AMP** and HEDIS data submissions. The PO must provide the health plan with a completed Roadmap section for each supplemental data source, all applicable attachments, the auditor's review findings and PSV results.

A complete and accurate audit is critical to the integrity of an AMP measure rate. Because an auditor must evaluate the final rate based on every step of the process leading to the rate, NCQA allows only a final audited measure rate rendered by one Licensed Organization to be used in another Licensed Organization's opinion without further review.

NCQA does not allow the portability of audit opinions at the process level (i.e., IS review); therefore, one Licensed Organization's assessment of vendor information systems is not transferable to another Licensed Organization. Only a final rate is portable and is allowed to be used by another organization.

AMP health plans are not required to collect POS documents for audited and approved PO supplemental data.

Auditor approval summary

To share the audited and approved PO supplemental data results with the health plan auditor, auditors must create an approval form to provide the PO to share with health plans using their data. Forms must be signed by the PO auditor and saved as a PDF file before they are sent to the PO. At a minimum, the following items must be addressed in the forms before the **AMP** health plan auditor can accept the PO auditor's supplemental data approval:

1. Data source.
2. Classification of data source (Standard, Nonstandard).
3. Measures/indicators that the data source was approved for reporting.
4. PSV performed and results.
5. Data source approval status (pass, fail).
6. Number of records in or size of the data source.

Note

- *Medical records collected as a part of supplemental data validation may be destroyed after the NCQA monitoring visit.*
- *If PHI documents are needed during the seven-year period, the Licensed Organization must retrieve them from the client.*

Planning the Onsite Visit**The onsite audit team**

After an initial PO Roadmap review and core-set selection, the auditor forms the team. **At least one** Certified HEDIS Compliance Auditor (CHCA) **must visit the plan. The auditor may base the team structure and the length of the visit on the** unique characteristics of the entity being audited. Auditors on the team have a mix of skills:

Team skills

- AMP knowledge.
- Data modeling skills.
- Claims experience.
- Information systems experience.
- Programming experience.
- Interviewing skills.
- Merger or acquisitions knowledge.
- Data warehousing experience.

Depending on the size and type of system to be reviewed, NCQA requires enough individuals for complete interviews and thorough system review and documentation, with the CHCA serving as the team leader.

Audit kick-off discussions

After the audit team is organized (early in the year or HEDIS season), the lead auditor meets with the organization (in person, by phone or through web presentation) to introduce the audit team **and each team member's** qualifications and disclose any work experience that could conflict with the audit. The auditor also selects the onsite visit locations, identifies offsite issues and makes offsite requests, such as source code and supporting documentation for the core set measures or noncertified measures, and discusses changes from previous years. During this call or another call, the audit team should discuss the onsite agenda, resolve issues and ensure availability of the requested documentation and staff.

NCQA recommends that a single-location onsite visit last **for at least a day**. Additional days may be necessary for multiple-location visits. The audit **must** address audit risk areas and accommodates the PO.

The kick-off discussion should be documented in the work papers and include, at a minimum, who attended the call and a summary of the discussion.

The Onsite Process

Site Visit

The onsite visit, a required part of the audit process, allows the auditor to investigate issues identified in the PO Roadmap and observe systems used to collect and produce measure data and query and review the data used for HEDIS reporting. An onsite visit can take up to **several** days and is conducted by an audit team. At least one CHCA must be present to lead the onsite visit; other team members do not need to be CHCAs. The auditor is required to keep a dated attendance sign-in sheet from the onsite visit.

The audit team interviews PO staff members; reviews the PO's information system structure, protocols and processes; and reviews the organization's measure-specific data collection processes with the staff responsible for measures selected. The team concludes the onsite visit with a closing session that shares initial findings and additional documents or corrective actions needed.

Opening Meeting

The opening meeting introduces the audit team to the PO staff in charge of **AMP** development and reporting and gives the PO an opportunity to present an overview of the entire **AMP** data collection process.

The members of the audit team explain how they conduct a **AMP** Audit Review. They reiterate the audit's purpose, the scope of the work, the required documentation, the interviews and tests they will conduct. Before the end of the meeting, interviews may be scheduled and the CHCAs receive or request additional information.

Onsite Audit Methods

The CHCA assesses the ability of the PO systems and processes to produce reliable **AMP** results, and the extent to which the PO staff has accurately interpreted the **AMP** clinical specifications. The auditor uses several tools and techniques, discussed below.

Interviews Throughout the onsite visit, the audit team interviews PO staff to gain insight into the accuracy and reliability of the **AMP** results. Members of the audit team may also accompany a staff member to another site where information is processed, or communicate via conference call with the staff located off site.

Onsite, the auditor may confirm some responses in the PO Roadmap and should interview staff members who are familiar with the PO's information systems and involved in the **AMP** data collection process. **Interviews are tailored to the organization's data production environment and issues raised by the Roadmap; they are not intended to be a review of the entire Roadmap. All interviewees and auditors must sign and date a sign-in sheet to indicate their participation in the audit.**

Discussion Topics and Recommended PO Personnel to Be Interviewed	
AMP team leader	<ul style="list-style-type: none"> • Overall data collection, data integration and reporting • Preliminary rate review and rationales
Quality improvement director	<ul style="list-style-type: none"> • Use of AMP information • Underlying data issues • Use of supplemental data
Information systems (services)	<ul style="list-style-type: none"> • All systems and databases supporting AMP reporting • Integration of supplemental data • Conduct queries
Operations management director	<ul style="list-style-type: none"> • Claims/encounter processing

Interview questions Interviews are tailored to the PO's **AMP** data production environment and issues raised by the PO Roadmap; they are not a review of the entire Roadmap.

- What coding methods are used and what degree of specificity is maintained?
- Is proprietary coding used? If so, how is it mapped to standard codes?
- On what forms are clinical data captured and what formats are used for the delivery vehicle?
- How are data delivered to the PO and what are the proportions by delivery type (electronic, mail, courier, fax)?
- How are data manipulated to produce the **AMP** repository from the entry or transaction files?
- What are the procedures for file and system back-up, access security, power protection, system upgrade and system modification?

Primary source verification This task confirms the validity of the source data described in the PO Roadmap. The auditor examines all paper forms and other input media (e.g., claims/encounters, practitioner credentialing documents, EDI protocols) used to collect **AMP** data.

The review verifies that the information from the primary source matches the output information used for **AMP** reporting. The review addresses content and format and traces the movement of data from the originating source to the **AMP** clinical repository to assess accuracy and completeness. This process is especially appropriate for electronic transmission of primary source data.

The auditor reviews the processes used to input, transmit and track the data, confirm entry and detect errors. For example, an answer in the PO Roadmap may state that all claims contain certain data (e.g., codes and dates) and the procedure manual may state that the data is required. The data entry process may provide for it and the data entry system may require it, but a review of actual claim forms may disclose that the data are often not submitted and replacement codes are used when the data are not present.

Forms and data to review Forms and data (including electronic submissions or EDI) that typically contain **AMP**-relevant data and which should be reviewed:

- Practitioner claims and practitioner encounters.
- Prescription data.
- Claims log (receipt and mailed payment tracking).
- Lab result forms or files.

- Registry or other supplemental data.
- Supplemental data forms.

Process review

The PO documents the processes for collecting, storing and reporting data. The auditor reviews the process and explores the POs methods for ensuring that policies and procedures are followed, focusing on the integrity and completeness of the data required for AMP. It is critical to document incentives for perform procedures properly.

Documentation processes and forms might not change from year to year. For initial audits, or in years where there are system or process changes, NCQA requires the auditor to review all applicable documentation. For subsequent audits, the auditor may exercise discretion when systems and processes have not changed. The auditor may observe certain procedures during the onsite visit; for example:

- Instructions and forms for submitting member-level information regarding enrollment additions, deletions and changes.
 - Documents specify data required to open and update records, and problems resulting from noncompliance.
- Instructions and procedures for collecting and entering credentialing and other practitioner-level data.
 - Instructions and procedures specify data required to open and update records, and problems resulting from noncompliance.
- Training and procedure manuals for claims and encounter, membership and practitioner data entry staff.
 - Documents describe objectives, methods and processes; how performance is monitored and measured and how proper execution is rewarded.
- Manuals for application system development methods, database development and design and decision support system use.
- Procedures for monitoring hardware function, capacity, physical state and access.
 - Log forms for all hardware activities, including back-up, failure response and recovery and system optimization techniques that clearly describe the data required and do not allow routine execution.

System or program review

To ascertain the accuracy of data in a file, the auditor must understand the systems and programs that govern the entry, transfer, editing and manipulation of the data. The PO supplies documents describing how particular computer systems or computerized files operate. Computer processes can be described in different ways, including text, code and flowcharts. Electronic files can be described by text, file layouts and data dictionaries.

Because NCQA requires auditors to review relevant systems and processes during an onsite visit, the auditor must review and understand data and systems-oriented documents, for example:

- Record file formats and descriptions for entry, intermediate and repository files that contain the information necessary for the auditor to perform a file scan and understand the results of the scan.

- Documentation for data receipt, entry, transfer and manipulation, showing how programs interact with the operations, if documentation is explicit about user options and program paths.
- Flow charts describing data flow and the systems involved.
- Descriptive documents of third-party code; date of receipt, including procedure, diagnosis and revenue codes, and other codes.
- Control system documentation, including logs, flow charts and codes for back-up, recovery, archiving and other control functions.
- Documentation of system upgrades and changes, including:
 - Project plans.
 - Project milestones.
 - Impact studies.
 - Test plans.
 - Test activity.
 - Results.
 - Sign-off.

The auditor carefully records all PO documentation received and examined, and includes the record with the Final Audit Report. It may be necessary in the reporting process to refer to documents examined by the auditors and to pinpoint evidence sources by document and section or subsection.

Observation

The auditor observes a process to ascertain the reliability and accuracy of reported information and whether procedures are followed through assessment of data entry or other data manipulation:

- Data entry of membership updates, claims or encounters and practitioner data.
 - The auditor confirms that all mandatory fields are entered with complete coding.
- Claims operations that may have overrides and exceptions and require explanations if they occur.
- Computer operations and system security plans.
 - The auditor confirms that prescribed procedures are followed.

During the observation process, the auditor follows a systems operator through receipt and entry or processing of several types of source data and documents whether the operator adheres to procedural guidelines.

The auditor has a prepared observation guide for each process and interviews the operator about the routine. The auditor may also use the observation guide to verify that all procedures ensure data integrity and may ask a claims processor to perform the following tasks:

- Enter the required fields.
- Enter as many diagnosis codes as the system will accept.
- Enter procedure codes to the maximum number of digits.

The auditor should also observe situations where data are processed inaccurately or incompletely. While observing the claims process, the auditor may ask the claims processor to:

- Enter an incomplete member number.
- Process the claim without a provider ID.
- Enter an inconsistent member diagnosis combination (e.g., male and cervical cancer).

As necessary and based on previous reviews of the systems or changes implemented between audit years, the onsite audit team should observe the systems and processes as necessary to ensure compliance with IS and HD standards. At a minimum, the audit team should ensure that all systems and processes used to produce AMP measure data are verified and understood when seen for the first time or when changes are made.

Data file content review

The auditor also examines data files, and may review and validate a number of file types to verify that the data are stored and processed properly and can be manipulated to produce accurate results; for example:

- Transaction files created to contain clinical events, membership and practitioner changes.
- Intermediate files created by extracts, queries and analysis applications.
- AMP repository files (i.e., input to AMP-measure computation programs).
- Denominator files for AMP measures.
- Sample files randomly selected from denominator files.
- Numerator files based on administrative data and supplemental data.

The first three file types listed above are related to the IS standards because they are associated with preserving the integrity of the data in the AMP repository. The auditor confirms the integrity of files for all categories. Review methods depend on file type; potential for corruption; complexity of the programs that build and update the files; and file access capability. By examining the file layouts, the auditor determines if certain fields are missing, for example:

- Multiple practitioner locations.
- Multiple practitioner specialties.
- Number of prior membership segments.
- Prior membership ID.

File content examination

- Request transaction file output and compare to a sample set of source documents (i.e., 20 or 30 records). Compare the data entry result to the entry documents' content for completeness, accuracy and format.
- Request a query to scan a file and produce a record whose contents match a given source document. Repeat this process for 20 or 30 records to compare a source document to a transaction file.
- Study the process that manipulates transaction files to produce an integrated repository record. Access a sample of repository records and look in the transaction files for data sources that support the final integration result.
- Simulate the actions that create numerator and denominator files by running queries against their predecessors. Because the programs producing the files may be complex, the auditor may run a query with some of the criteria

and confirm that the output contains all records that resulted from a more rigorous filter. For example, the auditor might use age and sex criteria only to build a query and to confirm that the output has a related denominator file as a subset.

- Test for reasonableness (e.g., membership data by age and gender).
- Review third-party data. Examine documentation that describes how the measure (or part of the measure) is collected, if calculated by the vendor. Identify how members are tracked from vendor classifications to PO classifications.
- Verify codes used to identify members who meet the **AMP** criteria (denominator or numerator).
- Verify adherence to small eligible population guidelines.

Data queries

- Run data queries to track specific cases from point of origin to final measure result. Refer to Appendix 5 for query requirements and examples.

Data Completeness Findings and Impact Determination

Before the onsite visit, the **auditor** reviews the PO Roadmap and identifies possible areas of concern. During the onsite component of the audit, the auditor assesses the PO's claims lag and encounter data submission rates, along with studies on data completeness that the PO may have performed. Data completeness issues must be quantified, and any *Biased Rate (BR) designation* must be supported by a determination of material bias.

IHA provides the auditor with commercial and Medicare **AMP** audit means and percentiles, to conduct reasonability assessments of the **preliminary** and final measure results calculated by the PO. After investigating data completeness concerns regarding the reporting method used, and along with year-to-year rate change analysis, the auditor uses the means and percentiles to conduct reasonability assessments of the initial and final measure results calculated by the organization. The auditor assigns *BR* to a measure whose rate changed beyond the bias thresholds or is either well below or well above the mean rate, and the plan cannot justify the changes.

For assessment of data completeness, NCQA and IHA provide the auditor with enrollment ratios of eligible members to product line. As with the means and percentiles, the auditor does not assign *BR* to a measure whose enrollment ratio is significantly above or below the mean enrollment ratio whether data completeness issues affect the measure rate.

Closing Conference and Follow-Up Documentation

At the conclusion of the onsite visit, the audit team prepares a written summary of the visit and conducts a closing conference to discuss preliminary findings and follow-up items.

Within 10 business days of the onsite visit, the auditor sends **written confirmation** of the initial findings conveyed in the closing conference, giving the organization reasonable time to review and respond.

Initial findings documents **must contain**:

- A list of unresolved questions and deficiencies found in the Roadmap during the visit, with corrective actions and their completion dates.
- A list of additional documents needed to complete the Roadmap or the onsite visit, with submission dates.

- The auditor's conclusions and preliminary assessments, with supporting evidence.
- The impact that items have on data collection and reporting, and specify any measures at risk.
- A timeline for finalizing the audit.

The Post-Onsite and Reporting Process

The nature of post-onsite work depends on the outcome of the onsite visit. While onsite, the CHCA usually finds issues that the PO can resolve before the **final rates are submitted and the** Final Audit Report is issued. The auditor reviews and re-audits the corrective actions and determines if they justify a change in the initial findings or audit results. The audit team sends the audit results to the PO and NCQA in the reporting phase of an NCQA **AMP** Audit Review.

Corrective Actions and Reassessment

Improving accuracy and reliability

The post-onsite phase may be an iterative process in which the PO responds to requests and the auditor incorporates the PO's documented comments and corrective actions, as appropriate. After the last review of materials forwarded by the PO, the auditor approves the final rates and results and produced the Final Audit Report. For some measures initially assessed *BR*, the PO can follow the auditor's recommendations to improve the accuracy and reliability of the reported rate. The auditor reviews the documents showing that the PO made the improvements and that the **AMP** measure rate accurately reflects performance. Corrective actions may include:

- Change software programs.
- Recalculate rates.
- Repeat file extracts with logic or parameter changes.
- Modify documents to match onsite findings.
- Initiate a new procedure and review its impact on reporting-year results.

Note: Auditors must question the plan about **all** significant changes in performance following the bias determination thresholds (e.g., a $\pm 5\%$ change from the previous year). Organizations must reply to auditor inquiries about rate changes, or the rate may not be reported and must be assessed *BR*. Responses should be substantive and specific, not merely a general confirmation of the reported rates in question.

The PO and the auditor agree on a completion date for corrective actions, usually at least two weeks before data submission. On or before the completion date, the PO gives the results, supporting documentation and comments to the auditor, who determines whether modification is necessary. If the PO declines to revise a noncompliant methodology, the auditor determines whether noncompliance affects reporting and designates the measure as *BR*. This information and the recommendations are included in the Final Audit Report. If the PO does not take corrective action and noncompliance does not significantly bias accuracy or comparability, this is noted in the Final Audit Report.

Review for sufficient corrective action

To determine if a corrective action is sufficient, the auditor reviews:

- Written or electronic documentation of revised numerator and denominator data and other data used in **AMP** determinations.
- Undocumented verbal communication or statements made by the PO.
- Revised programming logic used in measurement computation.
- The primary data source (e.g., claims or encounter form, or summarized claim detail forms).
- Other primary data sources that affect the PO's data and algorithmic integrity.

Note: To meet the AMP data submission deadline, all follow-up activities and corrective actions must be completed two weeks before the data file submission to TransUnion HealthCare.

Audit Results

PO results For self-reporting POs, audit results indicate the suitability of each measure for public reporting. The auditor approves the rate or result of each measure included in the audit, as shown in the table below. Additional instructions for data submission are:

Rate/Result	Notes
0-XXX	<i>Reportable.</i> Reportable rate for AMP measure. The rate of 0 includes instances when the PO calculated the rate but found that no members met the criteria specified in the denominator.
BR	<i>Biased Rate.</i> The calculated rate was materially biased. The auditor determines a result is not reportable due to material bias.
SD	<i>Small Denominator.</i> The PO calculated the result but the denominator was too small to report a valid rate (denominator between 1 and 29 members).
NB	<i>No Benefit.</i> The health plan did not offer the health benefit required by the measure (e.g., pharmacy).
NR	<i>Not Reported.</i> The PO did not report the measure.

Note

- If the denominator for any measure is 0, the result should be 0, BR, NB or NR. A rate of 0 indicates that the PO calculated the measure, but found that no members met the criteria specified for the denominator.
- For measures reported as a rate, **materially biased** is any error that causes a (+/-) 5 percentage point difference in the reported rate.
- Testing measures do not require an audit result. These measures are collected but not audited.
- Ensure that appropriate health plan members are reviewed and compared with the PO Master File.

AMP Data Submission

Final Audit Opinion	At the close of the audit, the auditor renders the Final Audit Opinion, which contains an Audit Review Statement, and submits it to NCQA 30 days after the AMP reporting deadline.
Data submission file (rates and results)	<p>IHA registers all AMP POs in November to determine their intent to self-report clinical measures, and provides information on data submission responsibilities to all self-reporting groups.</p> <p>In January, IHA provides POs with a standard file format for submitting data. The file includes numerators, denominators, rates and audit results.</p> <p>In May, the auditor signs off on the PO's data submission file to TransUnion HealthCare, which includes all data elements defined in the data submission file.</p>
Final date for submission	The final date for audited AMP data submission to TransUnion HealthCare is the AMP reporting deadline listed in "Data Collection and Reporting Timeline" in the

General Guidelines section of Integrated Healthcare Association California Pay for Performance Program: AMP 2018 Measurement Year Manual.

AMP PO Audit Review Statement

The template for the AMP PO Audit Review Statement follows. The auditor submits this document electronically to NCQA.

AMP PO Audit Review Statement

We have examined the 2018 submitted measures of [insert PO name] for conformity with the MY 2018 AMP Manual. Our audit planning and testing was constructed to measure conformance to the MY 2018 AMP Manual for all measures presented at the time of our audit.

This report is the [insert PO name] management’s responsibility. Our responsibility is to express an opinion on the report based on our examination. Our examination included procedures to obtain reasonable assurance that the submitted 2018 Performance Report presents fairly, in all material respects, the PO’s performance with respect to the AMP MY 2018 Physician Organization Manual. Our examination was made according to AMP Manual and, accordingly, included procedures we considered necessary to obtain a reasonable basis for rendering our opinion. Our opinion does not constitute a warranty or any other form of assurance as to the nature or quality of the health services provided by or arranged by the PO.

In our opinion, the 2018 submitted measures of [insert PO name] was prepared according to the MY 2018 Physician Organization Manual and presents fairly, in all material respects, the PO’s performance with respect to these specifications.

We understand that if the signatures we submit below are electronic, they have the same legal effect, validity and enforceability as original signatures submitted on paper.

(NCQA-Certified Audit Reviewer)

(Date)

(Responsible Officer)

(Date)

Organization ID: _____

Submission ID(s): _____

Management Representation Letter

At the conclusion of the audit process, each organization must sign a management representation letter. The letter may be provided to the organization at any point in the audit, however, the organization must complete and sign the document and return it to the auditor between May 1 and May 9, after the auditor completes final rate validation. Auditors must maintain the signed copy of this letter in their audit work papers.

Management Representation Letter Align. Measure. Perform. (AMP) Reporting

From Organization: _____

To Auditor: _____

Licensed Organization: _____

Measurement Year (MY): _____

Audit Type: _____

Organization ID	Submission ID

Note: List all organization and submission IDs associated with the audit this letter represents. Add rows as needed.

In connection with the organization's audit for the measurement year, we understand that the purpose of the audit is to express an opinion as to whether the data give an accurate, complete, reliable and valid representation of the organization's measure results as of May 9, 2019.

We acknowledge our responsibility for the accuracy of the data in accordance with the MY 2018 AMP program Audit Manual.

We certify and attest, to the best of our knowledge and belief, after careful review with key staff at the Organization, that the following representations apply to all data, processes, and results (hereinafter collectively, "data") used or submitted for AMP reporting:

- There have been no irregularities involving management or employees who have a significant role in AMP data processes, or who could have a material effect on the data.
- We have made available to you all relevant measure data and documentation of data collection processes.
- All information and attachments provided in the AMP Roadmap are accurate and complete.
- Data are accurate and not in any way false, untrue, invalid or misleading in any material way and are complete in all material respects in that no data required to be included therein, or necessary to make the data therein not misleading, have been omitted or changed.
- We acknowledge our responsibility for the design and implementation of processes and controls to prevent and detect fraud.

- We have no knowledge of any fraud or suspected fraud affecting our organization or involving:
 - Management.
 - Employees who have significant roles in AMP data processes.
 - Others where the fraud could have a material effect on the data.
- We have no knowledge of any allegations of fraud or suspected fraud that may have been received in communications from employees or former employees.
- There has been no noncompliance with requirements of regulatory authorities (e.g., CMS) that could have a material effect on the data in the event of noncompliance.
- The following have been properly documented and adequately disclosed:
 - All required members were included in the eligible population (e.g., if an organization’s Medi-Cal Managed Care submission should include dual-eligible members, make sure these members have been included).
 - Only appropriate members were excluded (e.g., ASO members, if there is a no-touch contract in place).
 - All required measures were reported.
 - Rates were produced using certified measure logic or approved source code using the current year’s specifications.
- We have disclosed all known data issues to our auditor and, by the “Submission Files to Auditors” PO deadline, completed all corrective actions assigned to us.

An authorized officer of the organization must sign this form and submit it to your auditor. The signature must be an actual signature or an electronic version (e.g., a JPEG file) of an actual signature.

(Signature)

(Date)

(Name)

(Title)

Final Audit Report Contents

When the audit is complete, the auditor prepares a Final Audit Report that includes the Summary Report and the IS Assessment findings. Within 30 days after the AMP reporting deadline, the auditor submits copies of the report to the PO and to NCQA, which uses it to evaluate the audit process and ensure that all audits are conducted according to guidelines. The report must provide enough information for NCQA to evaluate and conclude that the auditor’s results are supported and must include the following information.

AMP REPORT CONTENTS	
Licensed Organization	<ul style="list-style-type: none"> • Licensed Organization name. • Licensed Organization address.
Audit Team Information	<ul style="list-style-type: none"> • Name of auditor responsible for audit. • Role in audit. • Dates of involvement. • Years of audit experience.
PO Information	<ul style="list-style-type: none"> • PO name. • Organization address. • Organization and submission IDs. • Name and title of contact responsible for reporting. • Name and email address of contact who receives the AMP Seal.
Audit Information	<ul style="list-style-type: none"> • Scope of the audit indicating the measures reported. • Audit timeline with actual dates. • Auditor strategy and considerations (optional).
Supplemental Data	<ul style="list-style-type: none"> • List of all supplemental data files and types. • Intended measure use. • Audit activities and approval status for each data source. • Indication that the organization did not use any supplemental data.
Source Code Review	<ul style="list-style-type: none"> • Vendor used, if applicable. • Core set selected and results, if applicable. • Source code review results. • Results and rationales for the AMP measures. • A summary of the auditor's findings from the "Describe Impact on AMP Reporting Capability" column in <i>Appendix 2: PO IS Standards Compliance Tool</i>. The auditor assesses PO performance on each IS standard.
Final Audit Opinion	<ul style="list-style-type: none"> • Final Audit Statement. • A copy of all audit results and associated rates.

Other Reporting Requirements

CHCAs must retain all work papers, including the Final Audit Report submitted to NCQA.

NCQA recommends that CHCAs and Licensed Organizations retain audit documentation for seven years. At a minimum, work papers must include the documents listed below.

The Licensed Organization maintains protected health information (PHI) through the monitoring visit and the time frame allowed to appeal results. After that period, the Licensed Organization may destroy PHI but must maintain all other work papers for at least seven years. If PHI documents are needed during the seven-year period, the Licensed Organization must retrieve them from the client.

Note

- All Licensed Organizations are required to provide **either**:
 - Access to their full email system, **or**
 - All clients' emails, in PDF format, with links and attachments enabled, in a folder.

Licensed Organization Information and PO-Specific Information

- Current PO and Licensed Organization information:
 - Organization name, address, primary contact, additional audit participants' names and titles.
 - Audit team members, titles, skills and audit responsibilities, auditing and consulting history or relationship between the Licensed Organization and the PO or any PO affiliates for the past three years.
 - Copies of all current audit contracts or letters of intent with required NCQA language for indemnification and appeals processes.
 - Copies of all contracts with independent auditors showing current and historic relationships between the Licensed Organization and the auditor, and the scope of work.
- An audit timeline that includes negotiated and actual dates for at least:
 - Opening meetings or conference calls.
 - Receipt of PO Roadmap.
 - Offsite data requests and subsequent deliveries.
 - Onsite visits for each location.
 - Offsite activities such as source code review, document review, conference calls.
 - Follow-up documentation to the PO.
 - PO responses.
 - TransUnion HealthCare submissions by the PO to the Licensed Organization.
 - Final TransUnion HealthCare submissions.
- Audit correspondence (email and phone):
 - All correspondence among team members.
 - All correspondence between auditors and the PO.
 - All announcements from vendors to clients pertaining to Measure Certification.

When phone calls are held with the organization, phone logs must be maintained, or a summary of the conversation must be sent via e-mail back to the organization.

Offsite Activities

- The PO Roadmap papers:
 - The PO Roadmap executed by the organization and vendor, if applicable.
 - A paper or electronic copy of the **Management Representation letter**, with the appropriate signature and date.
 - Auditor notes from reviewing the PO Roadmap, including all preliminary issues and items to discuss before or during the onsite visit.
 - All requested documents.
 - All documents received from the PO (before the onsite visit) and auditor's notes and analysis for each, including if the issue is resolved or under discussion.
- Source code review:
 - If the PO does not use a vendor with certified measures, or for measures not covered under certification, the auditor's review notes (including reviewers, location, work dates and level of effort) and source code review reports for:
 - Repository creation and extraction programs.

- Denominator identification, including separate review of systems for determining continuous enrollment and member-month calculations sampling algorithms.
- Numerator algorithms.
- Core set selection documents, including rationales and results.
- A completed auditor's Decision Point Grid for each measure, referencing applicable HD standards and comments on the compliance with each standard.
- For plans with certified measures, an auditor's Decision Point Grid for each measure not covered in the Measure Certification Report.
- Certified Measure vendor's Final Measure Certification Report, if applicable.
- Documents that validate activities for the certified measures where the Certified Measure vendor status was *Fail*.
- Supplemental database findings:
 - A complete list of all databases, including type, process, measures affected, applicable incentives, issues and findings.
 - Source code (if appropriate).
 - Source code review results.
 - Policies and procedures documents.
 - Data mapping and integration assessment.
 - Sample files with format and content information (samples only).
 - Primary source verification notes, results and records or documentation that PSV was performed onsite (e.g., case number, result) so it can be re-created, if necessary.
- Query results and documentation collected from query review (e.g., screen shots, log repots).

Note: Documentation and data collected for PSV, including PHI, should be kept as part of the Certified Auditor's work papers through the monitoring visit and audit appeal deadlines. After the monitoring visit, PHI may be destroyed, but all other documentation must be kept for at least three years.

- Interim versions of the IS standards compliance tool.
- Audit correspondence (email):
 - Key correspondence among team members.
 - Key correspondence between auditors and the PO.
 - All announcements from vendors to clients pertaining to measure certification.

Onsite Activities

- A participant sign-in sheet, including the PO's name, the date and the location. Onsite participants and auditors must sign and date the sign-in sheet; participants who participate via the phone must be listed and indicated as such.
- A complete record of onsite activities, including agenda, participants, and supplements to the PO Roadmap.
- Comprehensive interview and demonstration notes or tools with participants, dates and times of sessions, other participants present during sessions and any issues discovered during the session.
- A summary of the visit, including follow-up documentation and follow-up requirements with target dates.
- Interim versions of the IS standards compliance tool with preliminary audit findings (indicate measures at risk).

- Copies of documents collected onsite; photos or scanned versions are acceptable. Alternatively, onsite papers may be uploaded to the **Licensed Organization's** FTP site, and clearly marked as pertaining to the onsite visit.

Audit Result Files

- Standard compliance tools:
 - A final, organization-specific IS Standards Compliance Tool, with auditor's notes on the adequacy of data collection, storage and manipulation of key files to produce accurate measures. The Compliance Tool also contains documentation of issues, resolutions, possible problem areas, comments on compliance with each standard as it affects **AMP** reporting; recommendations for improvement, and sufficient evidence to support audit results for all measures.
 - Preliminary rate submission tool with review notes, including this year/last year comparison, benchmark comparison, auditor's notes, questions and requests for additional information.
 - The PO's response to preliminary submission tool issues and rates (i.e., three-year rate comparison, benchmark comparison).
 - Final, locked TransUnion HealthCare submission.
 - Final Audit Report.
 - **Signed Management Representation letter for all audits performed.**
- Audit correspondence (email):
 - All correspondence among team members.
 - All correspondence between auditors and the PO.

Appendix 2

PO IS Standards Compliance Tool

Released November 2018

APPENDIX 2

PO IS STANDARDS COMPLIANCE TOOL

(To be completed by the auditor.)

IS Standards Compliance Tool Instructions

This tool is used by Certified Auditors to determine PO compliance with IS standards and if there is an impact on AMP reporting. A completed copy of this tool must appear in the auditor’s work papers. The last column indicates the IS system’s designation:

S = Significant impact on AMP reporting **M** = Minimal impact on AMP reporting **N** = No impact on AMP reporting

Note: *If the reporting impact is S or M, record the recommended corrective actions.*

IS Standards’ Audit Team Participants

Standard	AUDIT ACTIVITIES			AMP IMPACT
	Pre-Onsite Review and Results	Onsite Review and Results	Post-Onsite Review and Results	S, M, N Comments
IS 1.0 Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry				
IS 1.1 Industry standard codes (e.g., ICD-10, CPT®, HCPCS) are used and all characters are captured.				
IS 1.2 Principal codes are identified and secondary codes are captured.				
IS 1.3 Nonstandard coding schemes are fully documented and mapped back to industry standard codes.				
IS 1.4 Standard submission forms are used and capture all fields relevant to AMP measure reporting. All proprietary forms capture equivalent data. Electronic transmission procedures conform to industry standards.				

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Standard	AUDIT ACTIVITIES			AMP IMPACT
	Pre-Onsite Review and Results	Onsite Review and Results	Post-Onsite Review and Results	S, M, N Comments
IS 1.0 Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry				
IS 1.5 Data entry and file processing procedures are timely and accurate and include sufficient edit checks to ensure accurate entry and processing of submitted data in transaction files for AMP measure reporting.				
IS 1.6 The PO continually assesses data completeness and takes steps to improve performance.				
IS 1.7 The PO regularly monitors vendor performance against expected performance standards.				
IS 2.0 Enrollment Data—Data Capture, Transfer and Entry				
IS 2.1 The PO has procedures for submitting AMP-relevant information for data entry. Electronic transmissions of membership data have necessary procedures to ensure accuracy.				
IS 2.2 Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.				
IS 2.3 The PO continually assesses data completeness and takes steps to improve performance.				
IS 2.4 The PO regularly monitors vendor performance against expected performance standards.				
IS 3.0 Practitioner Data—Data Capture, Transfer and Entry				
IS 3.1 Provider specialties are fully documented and mapped to AMP provider specialties necessary for measure reporting.				

Standard	AUDIT ACTIVITIES			AMP IMPACT
	Pre-Onsite Review and Results	Onsite Review and Results	Post-Onsite Review and Results	S, M, N Comments
IS 3.2 The organization has effective procedures for submitting AMP measure -relevant information for data entry. Electronic transmissions of practitioner data are checked to ensure accuracy.				
IS 3.3 Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.				
IS 3.4 The organization continually assesses data completeness and takes steps to improve performance.				
IS 3.5 The organization regularly monitors vendor performance against expected performance standards.				
IS 4.0 Supplemental Data—Capture, Transfer and Entry				
IS 4.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes.				
IS 4.2 The PO has effective procedures for submitting AMP measure-relevant information for data entry. Electronic transmissions of data have checking procedures to ensure accuracy.				
IS 4.3 Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.				
IS 4.4 The PO continually assesses data completeness and takes steps to improve performance.				
IS 4.5 The PO regularly monitors vendor performance against expected performance standards.				

Standard	AUDIT ACTIVITIES			AMP IMPACT
	Pre-Onsite Review and Results	Onsite Review and Results	Post-Onsite Review and Results	S, M, N Comments
IS 5.0 Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity				
IS 5.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented.				
IS 5.2 Data transfers to AMP repository from transaction files are accurate.				
IS 5.3 File consolidations, extracts and derivations are accurate.				
IS 5.4 Repository structure and formatting is suitable for measures and enable required programming efforts.				
IS 5.5 Report production is managed effectively and operators perform appropriately.				
IS 5.6 The organization regularly monitors vendor performance against expected performance standards.				
IS 6.0 Data Integration and Reporting—Accurate AMP Reporting, Control Procedures That Support AMP Reporting Integrity				
IS 6.1 Data transfers to AMP measure vendor from AMP repository are accurate.				
IS 6.2 Report production is managed effectively and operators perform appropriately.				
IS 6.3 AMP measure reporting software is managed properly with regard to development, methodology, documentation, version control and testing.				
IS 6.4 The organization regularly monitors vendor performance against expected performance standards.				

Appendix 3

Glossary

APPENDIX 3

GLOSSARY

accuracy	The extent to which recorded data (on medical records, forms and computer databases) are error-free and reflect the defining events. Error sources are miscoding, misrepresenting facts, maintaining out-of-date findings, recording data for the wrong person, data entry and computer programming errors.
administrative database	Automated data, including claims and encounter systems used by the PO or health plan to manage the delivery of health services to members.
administrative method	Requires the PO and health plan to identify a measure's denominator and numerator, using transaction data or other administrative databases. The denominator comprises all eligible members (see eligible population). The PO reports a rate based on all members who meet the denominator criteria and who are found through administrative data to have received a particular service.
algorithm	A method used to create a calculated result. For example, algorithms are used to combine medical record results with administrative results to produce a measure's rate.
AMP repository	A database or file system that stores all the AMP information, including claims and membership and which may be updated during the data collection period.
anchor date	The date when the member must be enrolled with the PO. No gaps in enrollment may include this date.
audit result	Defines the suitability of measures for reporting. These results can be an approved rate of calculation or indication the measure is not reportable or biased (<i>BR</i>).
audit designation	Designations that are assigned by the HEDIS Compliance Auditor indicating the suitability of measures for public reporting.
bias (degree of bias)	Degree of error. AMP rate measures are reported using a 95 percent confidence interval.
carve out	An organization sponsor (e.g., employer, purchaser) contracts for a service or function (e.g., mental health, laboratory) to be performed by an entity other than the organization.
claim	A submission for reimbursement (e.g., from fee-for-service providers).
claims audit/error rate	A rate that indicates the reliability of a claims processing system. Most POs review a sample of processed claims to compute an error rate, usually expressed as financial and nonfinancial.
claims dependent denominator	To determine the eligible population through claims data (e.g., diabetic members are identified by claims showing diagnoses for diabetes or dispensing of insulin).
claim or encounter processing vendor	Includes any external entity with which the organization has contracted to process claims or encounters.

comprehensive data	Complete records of patient care. Information about a member's every encounter with the health care system.
concurrent audit	Evaluation of methods and data during the data collection period. AMP Audit Reviews take place during data collection, allowing POs to correct errors before data are reported.
continuous enrollment	The minimum amount of time, including allowed gaps, that a member must be enrolled in the PO and/or health plan to be eligible for the measure.
corrective action	An activity the PO or plan completes between the onsite visit and data submission to correct problems that may result in a <i>Biased Rate (BR)</i> .
database	Data collected and organized in a computer file for ease of expansion, updating and retrieval.
data completeness	Determination or evaluation of missing data. Data-completeness issues must be quantified and <i>Biased Rate (BR)</i> designations must be supported by determination of material bias.
data completeness assessment	Assessment of the impact of claims lag, encounter data submission rates and studies on PO and/or health plan data completeness.
data consolidation	A combination of data from multiple sources, such as multiple electronic sources or electronic and medical record sources.
data extraction	Collecting data from medical records or pulling data from electronic and automated systems.
data integration	A combining of data from multiple sources, with additional steps to ensure that duplicate data are removed, and remaining data are refined.
data integrity	Data that are unimpaired and not altered or destroyed.
data reliability	A measure of data consistency based on reproducibility and an estimation of measurement error.
delegate	A formal process by which the PO or health plan gives another entity the authority to perform certain functions on its behalf, such as provision of mental health care or laboratory services.
deviation	A process that does not strictly comply with AMP standards as published by NCQA.
DMHC	Department of Managed Health Care. The licensing body for managed care in California that oversees all full and partial Knox Keene licensed health care organizations.
EDI	Electronic data interface. Standard electronic formats used for collecting data that are imported into or exported from various systems.
encounter	A submission that is not linked to payment (e.g., from capitated providers).

enrollment or membership processing vendor	Includes any external entity with which the organization has contracted to perform enrollment or membership data processing functions. Vendors may include, but are not limited to, ancillary providers, third-party administrators, provider groups and intermediary organizations (e.g., IPAs, MSOs, PHOs).
enrollment or membership system	Captures data about the members and their enrollment information, including eligibility, enrollment dates or spans, and benefits.
EPO	Exclusive provider organization. A health insurance product that usually limits coverage to care from providers, or groups of providers, who contract with the health insurance issuer to participate in the organization's network.
FAQ	Frequently asked questions. FAQs are posted to the NCQA website on the 15th of each month.
FQHC	<p>Federally Qualified Health Center. Only FQHCs are considered primary care practitioners. This must be reviewed and approved by an auditor.</p> <p>To be certified as an FQHC, an entity must meet any one of the following criteria:</p> <ul style="list-style-type: none"> • Is receiving a grant under Section 330 of the Public Health Service (PHS) Act (42 United States Section 254a) or is receiving funding from such a grant and meets other requirements. • Is not receiving a grant under Section 330 of the PHS Act, but is determined by the Secretary of the Department of Health & Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a "FQHC look-alike") based on the recommendation of the Health Resources and Services Administration. • Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive federally-funded health center as of January 1, 1990. • Is operating as outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991. <p>For certification as an FQHC, the entity must meet all of the following criteria (in addition to one of the criteria above):</p> <ul style="list-style-type: none"> • Provide comprehensive services and have an ongoing quality assurance program. • Meet other health and safety requirements. • Not be concurrently approved as a Rural Health Clinic.
health plan	An organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population.
HMO	Health maintenance organization. See health plan .
homegrown code	A diagnosis or procedure code not recognized nationally but used by the PO or health plan. Commonly found in mental health and preventive care.

inclusiveness	The extent to which an entire population or defined group is intentionally included in a database.
industry standard code	A code used by the majority of health care facilities and providers. AMP measures use these codes in the specifications (CPT, ¹ ICD-10-CM, CMS1500 place of service, UB type of bill, revenue codes).
internally built database	A PO-created database containing claims or medical record information. These databases are often designed for other purposes and, if used for measure collection, are subject to audit. Examples include case management databases, utilization management databases or databases populated with medical record information.
map	A document showing how the PO or health plan cross-references homegrown codes to codes specified by HEDIS. The map must be complete and accurate.
MCO	Managed care organization. See health plan .
measurement year	The year that the health plan is evaluating through AMP measures, often referred to as the “data year.” Also, the year prior to the AMP reporting year; for example, AMP reporting year 2019 is based on measurement year 2018.
member	An individual (and the eligible dependents) who pays premiums to the organization as a member of the organization’s enrollment population. A member usually receives specified health care services from a defined network for a specified period.
nonstandard code	A code not used or recognized by the majority of practitioners and facilities (see industry standard code and homegrown code). These plan-specific codes must be mapped to industry codes for inclusion in HEDIS.
nonstandard supplemental data	Data used to capture missing service data not received through administrative sources (claims or encounters) or in standard files, whether collected by an organization, a provider or a contracted vendor. These types of data might be collected from sources on an irregular basis and may be in files or formats that are not stable over time.
PCP	Primary care practitioner. A physician or non-physician (e.g., nurse practitioner, physician assistant) who offers primary care medical services.
PHI	Protected health information. Information that can identify a specific person. Person-identified information is associated with names, social security numbers, alphanumeric codes or other unique individual information.
PO	Physician organization. Independent Practice Associations (IPA) or medical groups that contract with individual doctors to provide health care services. POs accept risk and manage the business of contracting and compliance with health plans on behalf of the PO’s individual providers.

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POS	Point of service. A HMO with an opt-out option that is accountable for financing and delivering a broad range of comprehensive health services to an enrolled population. Proof-of-service. Documentation from the legal health record that substantiates a service was rendered.
positive numerator event	Evidence of one measure-required service, event or diagnosis.
positive numerator hit	A member who satisfies the numerator requirements of a measure and who may be counted in the numerator. Some measures have multiple numerator requirements; for example, in the <i>Childhood Immunization Status</i> measure, the DTP numerator requires four separate immunizations for a member to be a positive numerator hit.
practitioner	A professional who provides health care services. Practitioners are usually required to be licensed as defined by law.
practitioner-data system	Any system used to process claims or encounters.
practitioner-processing vendor	Any external entity with which the organization has contracted to perform practitioner data processing functions. Vendors may include, but are not limited to hospitals, integrated delivery systems, IPAs, medical groups, behavioral health vendors.
product	An organized health care system that is accountable for financing and delivering a broad range of comprehensive health services to an enrolled population (HMO, POS, PPO, EPO).
product line	Commercial, Medicaid, Medicare.
provider	An institution or organization that provides medical services to patients. Examples of providers include hospitals and home health agencies. NCQA uses the term “practitioner” to refer to professionals who provide health care services; however, it recognizes that a provider directory generally includes both providers and practitioners, and that the inclusive definition is the more common usage.
reporting year	The year when AMP is reported and for which the volume is named. The year immediately following the measurement year.
required benefit	AMP measures evaluate performance and hold plans accountable for services provided in their members’ benefits package. Measure specifications include benefits or coverage categories (e.g., medical, pharmacy, mental health, chemical dependency) required during the continuous enrollment period.
standard supplemental data	Electronically generated files that come from service providers (providers who rendered the service). Production of these files follow clear policies and procedures; standard file layouts remain stable from year to year.
supplemental data	Data other than claims and encounters used by the organization to collect information about the delivery of health services to members.

supplemental database Automated data supplied by contracted practitioners, vendors or public agencies (e.g. immunization registries, schools or state public health agencies).

validity The extent to which data correspond to an actual state or an instrument that measures what it purports to measure.

Appendix 4

Measures in the Scope of **AMP Measure Certification**

APPENDIX 4

MEASURES IN THE SCOPE OF AMP MEASURE CERTIFICATION

Note: The final measurement set will be available later in the year at www.iha.org.

Encounter Rate for Clinical Measures

ENRST Encounter Rate by Service Type

Clinical Measures

Cardiovascular Conditions

CBPH Controlling Blood Pressure for People with Hypertension

CBP Controlling High Blood Pressure

SPC Statin Therapy for Patients With Cardiovascular Disease

PDC Proportion of Days Covered by Medications—Renin Angiotensin System (RAS) Antagonists, Statins

PDC Proportion of Days Covered by Medications—Statins

Diabetes

PDC Proportion of Days Covered by Medications—Diabetes All Class

CDC Diabetes Care—HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam, Nephropathy Monitoring, BP Control (<140/90), **Optimal Diabetes Care (Hba1c Control, Eye Exam, BP Control, Medical Attention Nephropathy)**

SPD Statin Therapy for Patients With Diabetes

SUPD Statin Use in Persons With Diabetes

Musculoskeletal Conditions

LBP Use of Imaging Studies for Low Back Pain

ART Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

OMW Osteoporosis Management in Women Who Had a Fracture

Prevention and Screening

CIS Childhood Immunization Status—**Combination 10**

IMA Immunizations for Adolescents—**Combination 2**

CHL Chlamydia Screening in Women

CCS Cervical Cancer Screening

CCO Cervical Cancer Overscreening

BCS Breast Cancer Screening

COL Colorectal Cancer Screening

ABA Adult BMI Assessment

Respiratory

AMR Asthma Medication Ratio

CWP Appropriate Testing for Children With Pharyngitis

AAB Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis

APPENDIX 5

QUERIES

Onsite and Offsite Query Instructions

All auditors are required to conduct queries as part of every audit. Request a query from at least four of the five groups. If your Licensed Organization's standard queries are different, do not stop performing them; add them to enhance the data review. Save results from requested queries in the work papers for review during monitoring. When appropriate, run queries on the results (e.g., numerators, denominators) produced from the vendor's certified code and run them onsite.

For each query selected, list the query, explain why it was selected (i.e., intended use/outcome) and state the results (include screen shots or output). If the query requires primary source verification, review a minimum of two measures and five cases per measure, expanding to additional measures and cases if errors are found.

These queries mirror those found in Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures, and may not be applicable to all AMP organizations.

Group 1: Overall Demographics	Group 2: Data Loading Checks	Group 3: Onsite Drill-Down
<ul style="list-style-type: none"> • ENP for all product lines. • Membership by month. • Ensure that Exchange members are included in the commercial population. 	<ul style="list-style-type: none"> • Transactions by month (i.e., pharmacy, lab). • EHR/HIE files: Confirm that fields in the files match the system they were extracted from (date of service=date of service and not another date). • Pharmacy transactions with negative numeric values (to identify reversals and whether the organization is double counting services). • De-duplication of pharmacy data loads to check for double counting. • Data quality reports after data loads. Have organizations produce their data quality reports to show the number of records in-loaded vs. what is in the HEDIS repository. The comparisons should close to equal. If there are variances, ask if there are missing data (i.e., medical claims, pharmacy, supplemental data). 	<p><i>Review positive and negative cases for:</i>¹</p> <ul style="list-style-type: none"> • Numerator hits in the source systems. • Numerator misses in the source systems. • Enrollment for members in the denominator.

¹ When possible, these queries should be performed onsite through a visual review of the systems. Auditors must collect documentation of results.

Group 4: Negative Case Checks		Group 6: Mapping Result Checks ²
<ul style="list-style-type: none"> • Members who did not qualify for a measure due to CE breaks. • Frequency of codes loaded into software. For example, check the frequency of primary diagnosis codes to look for missing or incorrect values. • Members who did not qualify for the EP. For example, run source code that identifies diabetics to look for diabetic members not included—no CE, only one claim. 		<ul style="list-style-type: none"> • <i>Provider mapping review</i>: Ensure that providers are appropriately mapped and affect measures that require specific specialties. Queries can be based on the logical groups in Volume 5. • <i>Nonstandard coding review</i>: Use a frequency of codes list from the organization to ensure that the mapped codes affect the appropriate and specific measures, and that they are counted as hits. • <i>Lab code review</i>: Review the frequency report of lab result codes in descending or ascending order. This type of list often identifies invalid results; the auditor can ask how the plan handles the data.

²Mapping review and approval are required, but these queries validate the effect of the mapping on the measures.