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

Audit Review Guidelines Measurement Year 2026

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Measuring quality. Improving health care.

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Appendices

Appendix 1: Roadmap for Self-Reporting POs MY 2026 (PO Roadmap)
Note: *The Roadmap is not included in this document. Contact your auditor to receive sections that apply to your PO.*

Put the cursor on an appendix title; press Ctrl and click the left mouse button to navigate to the appendix.

Appendix 2: PO IS Standards Compliance Tool

Appendix 3: Glossary

Appendix 4: Measures in the Scope of AMP Measure Certification

Introduction

Background

The clinical quality measures can be found in the *Integrated Healthcare Association California Align. Measure. Perform. (AMP) Programs: Measurement Year (MY) 2026 AMP Technical Specifications* 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 Provider Organization (PO) performance. The audit review of the clinical quality 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 quality measures included for the AMP reporting initiative.

Contents of This Manual

AMP Audit Process 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, Information System (IS) standards compliance tool and a glossary.

What's New in This Manual

- Revised applicable measures in Appendix 4.
- Updated the MY 2026 Audit Timeline.
- Minor language revisions and corrections throughout (notable revisions are in red font).

If You Have Questions About the AMP Programs

Policy Clarification Support

NCQA provides different types of policy support to customers, including a function that allows customers to submit specific policy interpretation questions to NCQA staff through My NCQA.

AMP Technical FAQ

The AMP Technical FAQ and Policy Updates clarify HEDIS and AMP uses and specifications, and are posted on the IHA website, as needed.

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 reserves the right to publicly display the information on the reported issue, including, but not limited to, the affected organization, the specific data error, and the associated resolution. We will display the information on a dedicated public-facing webpage on the NCQA website. NCQA may also revise affected products.

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 Process for Health Plans

AMP-Specific Modifications to the Health Plan HEDIS Compliance Audit

Enrollment in the PO

The Certified Auditor confirms that the health plan appropriately applied enrollment at the PO level, as specified in the *AMP General Guidelines.* 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 an organization completes the current Record of Administration, Data Management, and Processes (Roadmap). The Roadmap includes an inventory of sources contributing to measurement and captures information about an organization's information systems and data management. 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.

Supplemental data

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. 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. The PO sends the health plan all necessary documentation to support the use of supplemental data. All tasks must be completed by required deadlines in the audit timeline.

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 completed Roadmap documentation for each supplemental data source, all applicable attachments, the auditor's review findings and PSV results.

Note: *AMP health plans are not required to collect proof-of-service documents for these audited and approved PO data.*

Benchmarks and thresholds

The Certified Auditor validates the reasonability of the PO data reported by the AMP health plans by:

- At a minimum, comparing PO rates reported in the current AMP 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 AMP Contracts Roster 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 that rates are submitted only for product lines in which members are enrolled.
- Perform year-over-year comparisons of total enrollment.
- Cross check total enrollment data with ENRST.
- Ensure measure certification ID and measure certification version IDs are populated for all certified clinical quality measures.
- Check each AMP PO ID (unique ID including five digits plus two subunit digits) file:
  - For a record for each clinical measure.
  - For ENRST.

Measure-specific

- Ensure that the sum of the denominators and numerators of each age group equals the total denominator and numerator reported for the overall age group, for all applicable measures with age stratifications (e.g., Chlamydia Screening).
- For all measures assessing the same denominator population across multiple numerator events (e.g., Prenatal and Postpartum Care), ensure that the denominator 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 except for the Race/Ethnicity Description of Membership measure.
- Ensure that the reported numerators, denominators and rates follow the requirements outlined in the measure specifications and data file layouts edit checks (e.g., health plans must report the denominator for each indicator of the Encounter Rate by Service Type measure as total member months).

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 2026 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; R	*Reportable. A reportable rate was submitted for the 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.*
BR	*Biased Rate. The calculated rate was materially biased. The auditor determines a result is not reportable due to material bias.*
NR	*Not Reported. The health plan chose not to report the measure (may only be used for testing measures).*
*NB**	*No Benefit: The health plan did not offer the health benefit required by the measure (e.g., pharmacy).*

**Benefits are assessed at the global level, not at the service level (refer to the AMP MY 2026 Technical Specifications, General Guideline: Audit Results).*

Note

- *For measures reported as a rate, **materially biased** is any error that causes a (+/-) 5 percentage point difference in the reported rate.*
- *Testing measure results are collected but are not required to be audited.*
- *Small Denominator (SD) is not a valid rate/result for health plan clinical data because IHA aggregates all health plan/PO data for final PO clinical results. If a health plan reports a measure with a denominator of less than 30, the plan should also report the numerical rate for that measure (i.e., do not report SD as the rate).*

Data submission

The final date for audited AMP data submission to IHA's subcontractor, FinThrive HealthCare, Inc., is shown on the "Data Collection and Reporting Timeline" in the *AMP Program Guide.* The timeline also shows the date when FinThrive HealthCare, Inc. provides the standard format for submitting data.

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

Final AMP Audit Opinion

At the close of the audit, the auditor renders the Final AMP Audit Opinion, which contains an audit review statement for AMP data. The Final AMP Audit Opinion must be submitted to NCQA within 30 days after the HEDIS commercial reporting deadline.

Final AMP Audit Report

When the audit is complete, the auditor prepares a Final AMP Audit 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 AMP Audit Report must be submitted to NCQA within 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 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 2026 submitted measures of [**insert health plan's name here**] for conformity with the Integrated Healthcare Association Align. Measure. Perform. Programs: AMP MY 2026 Technical Specifications and the AMP MY 2026 Audit Review Guidelines. Our audit planning and testing were constructed to measure conformance to the AMP MY 2026 Technical Specifications (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 2026 AMP Audit Manual. Our examination included procedures necessary to obtain reasonable assurance that the MY 2026 submitted measures were generated according to the AMP MY 2026 Technical Specifications 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 2026 submitted measures of [**insert health plan's name here**] were prepared according to the AMP MY 2026 Technical Specifications 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 AMP Audit Report submitted to NCQA, the auditor retains additional work papers related to the AMP audit review and makes them available on request for monitoring purposes. Work papers include all relevant documentation completed, requested or reviewed during the AMP audit review meeting. NCQA requires audit documentation and work papers to be retained for 7 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 MY 2026 *Volume 5: HEDIS Compliance Audit™*.

AMP Audit Standards for POs

Overview

HEDIS Compliance Audit standards describe requirements for AMP clinical data capture, management and reporting processes; they are the foundation on which Certified HEDIS Compliance Auditors base the PO's ability to report data accurately and reliably.

This section includes the standards 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 the audit process.

Auditors must consider organization compliance with the IS and HD standards as appropriate to their measure reporting requirements. To verify compliance, NCQA requires that all applicable items be evaluated during an initial audit engagement or when there are changes to applicable systems, processes or staff after an evaluation.

The standards are divided into two sections that are used in the AMP Audit Review.

1. **IS standards:** Because AMP clinical data depend on the quality of the PO's information systems, the IS standards measure how the PO captures, manages, integrates and reports medical, service, member and vendor data. A PO without adequate capabilities for processing health information cannot report measure information accurately and reliably.

   The standards specify the minimum requirements for information systems and criteria for data management and reporting. In short, meeting the IS standards ensures that the PO has effective IS capabilities and controls for measurement.

2. **HD standards:** Auditors use the HD standards to assess the AMP clinical data compliance (i.e., if a PO adhered to measure specifications).

Auditors review the recommended capabilities and results for each IS and HD standard. The review focuses on the PO's ability to comply with the standards and substantiate measure results.

The following sections list the typical products, outputs and documents, but auditors may also review items that affect compliance and reporting.

Information System (IS) Standards

IS R Data Management and Reporting

IS R1 The PO's data management enables measurement.

- Data standards, information systems and processes for transferring and integrating source files are fully documented.
- File layouts, data models and data dictionaries used by the PO for data management are complete.
- Data source identifiers are clear and documented.

IS R2 Data extraction and loads are complete and accurate.

- Transfer protocols capture all data elements for measurement.
- Referential integrity is maintained during transmission.
- PO ensures extraction, and loads do not result in unintended data modification, deletion or generation.

IS R3 Data transformation and integration is accurate and valid.

- File conversions maintain referential and data integrity.
- Information tagging to enable measurement is accurate and valid.
- Modifications, normalizations and mappings to conform with data models, coding systems and measure requirements are documented and valid.
- Processing and transformation do not result in inappropriate data modification, deletion or generation.

IS R4 Data quality and governance are components of the PO's data management.

- PO's design, implementation and improvements to its data management approach supports complete, valid, accurate and reliable measurement.
- Internal governance structures include responsibilities for data quality and integrity.

IS R5 Oversight and controls ensure correct implementation of measure reporting software.

- Reporting protocols and arrangements with vendors allow inspection, auditing, correction and resubmission of data.
- Use of certified measure logic is confirmed.
- Reports demonstrate that data and results from implementing measure reporting software are complete and accurate.

IS R6 Cybersecurity practices are in place to promote protection and resiliency of the systems and data used for measurement.

- A vulnerability management plan is in place to identify security risks to internal systems used for measurement.
- PO monitors for security risks associated with third-party vendors that may affect measurement.
- PO considers safeguards to support continued measurement activities following a security event.

Measure Certification

No item is affected by Measure Certification. The auditor is required to assess compliance with these standards, including transfer of data from the PO for implementation of measure software. 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).

IS C Clinical and Care Delivery Data

IS C1 Data capture is complete.

- Electronic standards, formats and protocols ensure capture of all data elements.
- Data entry processors enter all required data elements.
- PO ensures data are not modified, deleted or generated during capture.
- Reports indicate data completeness.

IS C2 Data conform with industry standards.

- PO uses industry standard data models, coding systems and layouts.
- Nonstandard data models, coding systems and layouts are fully documented.
- Data modification, normalization and mapping are appropriate and do not inappropriately impact measures.
- Processing and transformation do not inappropriately modify, delete or generate data.

IS C3 Transaction file data are accurate.

- PO systems and protocols include edit checks and controls to confirm accuracy.
- Comparison of a sample of transmitted files with source documents ensures data are accurate.
- Reports indicate data source impact on results.

IS C4 PO confirms ingested data meet expectations for data quality.

- PO maintains standards and requirements for inbound data to ensure data quality.
- Internal systems and processes identify data quality issues.
- Controls are in place to evaluate and monitor quality of data used by the PO.

Measure Certification

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

IS A Administrative Data

IS A1 Data conform with industry standards and measure requirements.

- Standard layouts and forms are used.
- Medical service transaction files include industry standard codes (e.g., ICD-10-CM, HCPCS).
- Nonstandard layouts, forms and codes are documented, and mapping is appropriate.
- Mapping and normalization of provider specialty comply with measure requirements.

IS A2 Data are complete and accurate.

- Electronic standards, formats and protocols ensure capture of all data elements, required codes and characters for the appropriate system.
- PO ensures data are not modified, deleted or generated during capture.
- PO ensures data processing, transformation or reconciliation produces the intended result.
- Reports indicate data completeness and impact on reporting.

IS A3 Membership information system enables measurement.

- PO's membership system can accommodate:
  - Changes to product line.
  - Changes to product.
  - Methods for defining coverage start and end.
  - Methods for identifying dual enrollment.
  - Multiple changes to membership status.
- Processing and transformation of membership information does not inappropriately modify, delete or generate data.

Measure Certification

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

Measure Determination (HD) Standards

HD 3.0 Algorithmic Compliance

HD 3.1 Summary-level calculations are arithmetically correct and precise.

- Code and program flowcharts ensure accurate computing of:
  - Row and column totals.
  - 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 measure data collection or reporting to an external software vendor, software vendor data meet all applicable NCQA Compliance Audit standards.

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

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

- Studies and reports:
  - Determine if the PO reviews software vendor performance against quality and timeliness standards.

Ensure that no data are lost or modified during transfer among software vendors.

Ensure that software 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 software vendors, the PO coordinates software vendor activities to safeguard the integrity of AMP data.

- Flowcharts determine if the data flow among software 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 an 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 MY 2026 Technical Specifications.*

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. Lists of Licensed Organizations and Certified Auditors are posted on the NCQA website.

Monitoring and Oversight of AMP Audits

To ensure the continued success of the audit program, NCQA administers a monitoring program that gives constructive feedback to Licensed Organizations and Certified HEDIS Compliance 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 is consistent across all Licensed Organizations and Certified HEDIS Compliance Auditors.
- Identify opportunities for improvement (design and implementation).

NCQA evaluates the consistency of audit practices across Licensed Organizations and auditors by observing individual Certified HEDIS Compliance Auditors as they conduct audits and reviewing work papers for evidence that audits conform with NCQA methodology and documentation standards.

Performance categories — NCQA assesses performance by Certified Auditors and Licensed Organizations in five major categories.

1. ***Audit process*** — Audit strategy, team selection, preparation and initial assessment.
2. ***IS assessment*** — Evaluate information systems and processes for data management and measure reporting.
3. ***Measure compliance and preliminary rate review*** — Determine compliance with AMP technical specifications and evaluate 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 activities and decisions in all major areas: audit processes, preliminary rate review, supplemental data review, final rate review and overall audit effectiveness.

Monitoring results

NCQA focuses on:

- Contract review.
- Client communication.
- Audit Approach, inclusive of:
  - Roadmap assessment.
  - Supplemental data review.
  - 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), if applicable, to NCQA for all identified areas of improvement.

NCQA reserves the right to monitor the quality of the Audit Program (including the right to accompany auditors on audits as an observer) and organizations' satisfaction with the program.

Portability of Opinion

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 "portability" of audit opinions at the process level (i.e., IS review); therefore, one Licensed Organization's assessment of vendor's 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 propertyof 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.

Audit Appeal and Grievance Procedures

Licensed Organization responsibility

An appeal process gives an audit client the opportunity to file a complaint or appeal an audit result 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 notifies the NCQA Audit program, in writing, within 2 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 HEDIS Compliance 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.

NCQA Measure Certification Program™

Health plans and POs that self-report clinical measures must contract with an NCQA certified measure vendor or directly with NCQA to certify their measure logic. Source code review is no longer an allowable audit task.

Refer to *Appendix 4: Measures in the Scope of AMP Measure Certification* for the full list of measures in the scope of AMP Measure Certification.

The Certified Auditor must review each vendor's or organization'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 2026 measure certification testing process are listed on the NCQA website. The deadline for vendors to complete AMP MY 2026 measure certification was September 1, 2026.

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 *Marketing* General Guideline in the *Integrated Healthcare Association Align. Measure. Perform. (AMP) Programs: MY 2026 Technical Specifications.*

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.

Audit Process

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

- **Audit Validation Activities:**
  - Contract Execution.
  - Roadmap Assessment.
  - Supplemental Data Validation.
  - Planning the Audit Review.
- **Audit Review:**
  - The Audit Review.
- **Follow-Up and Reporting:**
  - Documents and Corrective Actions.
  - Audit Results.
  - Data Submission.
  - Management Representation Letter.
  - Final Audit Report.

Audit Validation Activities

Many required tasks and activities must be completed for a successful AMP audit. Auditors should work with the organization to ensure that all activities are completed, even if they are not completed in order, to ensure that final audit results are not at risk. All activities must be conducted in accordance with the HEDIS Audit Timeline, especially for activities with non-negotiable dates.

- Contract Execution.
- Roadmap Assessment.
- Supplemental Data Validation and Electronic Clinical Data Systems (ECDS) auditing.
- Planning the Audit Review.

Contract Execution

Select an NCQA-Licensed Audit Organization

The first activity 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 the scope of the audit. 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.

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, several audit milestones have firm deadlines. When necessary, and if permitted, the Licensed Organization and auditor may adjust deadlines for certain tasks to ensure successful completion. Organizations should work closely with their auditor to complete all tasks by the deadline. and we encourage completion of activities earlier than the deadline when possible.

Note: *Auditors should work carefully with key staff members, including organization executives, if milestone deadlines are not met. If some milestones such as the Roadmap receipt date, the supplemental data stop date or data submission deadlines are missed, the organization could be at risk of not being able to use some data and measures could be assigned Not Reported (NR) or Biased Rate (BR).*

Activity or Milestone	PO Deadline	Health Plan Deadline
PO contracts with an NCQA-Licensed Organization.	*October 1, 2026*	
Measure Certification Deadline. *Final date for vendors to earn AMP Measure Certification to demonstrate that coded measures meet current NCQA standards and product accurate and comparable results.*	*September 1, 2026*	
Validating supplemental data may begin only if all Roadmap documentation, including attachments, are complete and submitted to the auditor and data collection is complete for nonstandard supplemental data sources. ***Note:*** *Because the collection of some nonstandard electronic clinical data files does not stop, auditors may validate these data on this date as long as the completed Roadmap section has been submitted.*	*November 2, 2026*	
Audit review meetings begin. Audit review meetings are not to be held prior to receipt of the Roadmap.	*After December 2, 2026*	
PO submits the completed current year's Roadmap to the auditor. This includes supplemental data Roadmap documentation. The auditor must receive the Roadmap by the January deadline or at least 2 weeks before the audit review, whichever date is earlier.	*By January 29, 2027*	
Supplemental Data Collection Deadline. *Organization submits all documentation, including Roadmap Section 4 and all applicable attachments, and stops all nonstandard data collection and entry. All amendments to supplemental data Roadmap documentation must be complete. There are NO exceptions! Failure to meet this deadline could result in inability to use supplemental data to report rates. Supplemental data sources not identified with a complete Roadmap documentation by this date cannot be used for AMP reporting.*	*February 5, 2027*	*February 26, 2027*
Supplemental Data PO Validation Deadline. *Auditor finalizes approval of all supplemental data for* **POs**. *Primary Source Verification (PSV) for nonstandard supplemental data must not occur prior to February 6, unless the PO finished all supplemental data processes, collection and entry. There are no exceptions!*	*March 12, 2027*	
Organization submits preliminary rates to the auditor for review. *Auditors should review preliminary rates based on the current year's specifications.*	*April 2, 2027*	
Supplemental Data Health Plan Validation Deadline. *Auditor finalizes approval of all supplemental data for* **health plans.** *Primary Source Verification (PSV) for nonstandard supplemental data must not occur prior to February 27 unless the health plan finished all supplemental data processes, collection and entry. No exceptions!*		*April 2, 2027*
Supplemental Data to Health Plans: *AMP health plans receive the audited supplemental data files and audit results from the PO.*	*April 2, 2027*	
Preliminary rate review is completed by the auditor. This date is the latest when this review should be completed. NCQA encourages preliminary rate review to take place earlier in the audit process.	*By April 16, 2027*	
Audit reviews (onsite or remote) are completed.	*By April 22, 2027*	
Submission Files to Auditors: *Self-reporting POs and health plans send submission files to auditors.*	*April 26, 2027*	
Auditor-Locked AMP Results: *Self-reporting POs and health plans submit auditor-locked AMP clinical results to FinThrive HealthCare, Inc. Health plans must submit results for all clinical measures for each contracted PO with a signed AMP Consent to Disclosure Agreement. The auditor approves the final rates that reflect all data, including supplemental data. The Management Representation Letter is due.*	*May 7, 2027*	

Activity or Milestone	PO Deadline	Health Plan Deadline
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.*	*August–September 2027**	
Appeals Hearing: *The AMP Appeals Panel reviews and decides on all appeals to change quality results, if needed.*	*September 2027**	
Licensed Organizations submit Final Audit Reports to NCQA.	*September 2027**	
Resubmission of Auditor-Locked AMP Results: *Self-reporting POs and health plans submit auditor-locked AMP clinical results to FinThrive HealthCare, Inc., if needed.*	*September 2027**	

**The timeline for these activities may change. Exact dates will be included in the Final MY 2026 Program Guide, to be released on December 15, 2026.*

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 managing 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 coordinate the audit review meetings.

NCQA requires the organization to give the auditor a complete, current year's PO Roadmap *every year* (the MY 2026 PO Roadmap must be submitted for MY 2026; a copy of the MY 2025 Roadmap is not acceptable). All Roadmap documentation must be received by the auditor by the January deadline or at least 2 weeks before the site visit, whichever is earlier. The February deadline allows for amendments to Roadmap documentation only and does not represent additional time to complete the Roadmap. Auditors should encourage the PO to complete the Roadmap sooner, if possible.

At the conclusion of the audit, each organization must sign a Management Representation Letter. Although the letter may be provided to the organization at any point in the audit, the organization must complete, sign it and return it to the auditor between April 26 and May 7, 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 HEDIS Compliance Auditor's assessment of compliance with the audit standards. The auditor uses the PO Roadmap and its supporting documentation for the 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 audit activities.
- Identify areas that require clarification.

Supplemental Data Validation and ECDS Auditing

In supplemental data validation, the auditor confirms that all supplemental data used by the organization for AMP reporting meet audit standards and are accurate. The auditor works with the organization to set appropriate interim milestones to ensure supplemental data deadlines are met.

Audit requirements

There are two distinct categories of supplemental data: standard and nonstandard. The auditor determines how to categorize the supplemental data source and communicates 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.

All supplemental data are subject to annual audit review; which audit is used differs only in the degree of review required.

The auditor conducts separate validation for each source of supplemental data, which includes a review of data receipt or data capture, data file formats and quality control processes.

The auditor documents whether a supplemental data source was previously audited and the audit decision. This information is especially important when waiving PSV for a nonstandard supplemental data source in subsequent years of use by the PO.

…for all supplemental data

The auditor reviews Roadmap documentation to ensure that the entity 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 (date of service, provider identification, diagnosis and service codes) and evidence that tests orservices were performed and not merely ordered.

The auditor evaluates the procedures for capturing, managing, mapping, importing and reporting the data. The organization and the auditor analyze the impact of each supplemental data file on reported AMP rates, including measures reported using the ECDS methodology. Analysis must be done by the submission deadline. Analysis can be done in a variety of ways, including, but not limited to:

- Review of measure rates before and after loading each supplemental data file.
- Comparison 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.

…for nonstandard and member-reported supplemental data

In addition to the tasks performed for “all supplemental data,” the auditor:

- Evaluates quality control oversight of the organization’s staff who build or maintain nonstandard supplemental data. The auditor ensures:
  - Forms or tools are used to collect data elements according to the measure specifications.
  - Appropriate staff are rendering services, if measures have a

requirement for provider type.
  - Ensures that data come from acceptable sources.

Conducts validation of nonstandard supplemental data, including primary source verification (see below).

PSV

Primary source verification, a process to ensure the integrity of data contributing to HEDIS rates is consistent with the source system documentation.

PSV is required annually, without exception, for:

- First-year nonstandard supplemental files.
  - Including first-year files using the C-CDA or FHIR data standard.
- All files where AI or machine learning is involved.

PSV may be conducted, as needed, to evaluate data integrity for:

- Standard supplemental files.
- Tenured nonstandard supplemental files (i.e., second year or more of use).
- Tenured C-CDA and FHIR files (i.e., second year or more of use).

Auditors assess factors affecting the stability of the file and integrity of the data, as well as the potential for bias to measure rates, to determine if PSV is needed.

Considerations include, but are not limited to, processes for data collection and exchange, prior year PSV results, changes from the prior year (e.g., data elements, measures, migrations, mappings, new connections, data volume), the demonstrated rigor of an organization's internal validation protocols, and impact to measure rates. Indication of the file stability and data integrity, as well as decisions to not perform PSV must be fully documented in audit workpapers.

PSV should not be performed for:

- Files from Data Aggregator Validation validated streams.

PSV requires the following steps:

- It is after November 3 of the measurement year.
- Roadmap documentation is complete and submitted.
- The organization finishes collecting the data and closes the files for input by the deadline in the Timeline (except electronic clinical data that are continually collected).
- 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.
- A list of sampled events is provided 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.
  - That the POS document was created before January 1 of the reporting year.
  - That, when applicable, the POS document contains all the elements required for the measure.
- EHR extracts that are not specific to a measure, and rely on integration with other data sources and measure logic, might not contain all elements for a measure.
  - That the POS document contains appropriate and correct data elements (e.g., dates, procedure, diagnosis, provider information, member information).
- When reviewing EHR extracts, it is possible these conditions are not always met if the file relies on other data sources (e.g., claims) and measure logic.
  - 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
• *Laboratory and radiology reports.* • *Sections of the member's legal health record showing service or assessment.* – *Human readable* C-CDA files *are not acceptable POS documents.*

Sample sizes for primary source verification

The sample size for PSV must be sufficient to assess the accuracy of the information. The auditor may determine PSV sample sizes based on targeted or stratified sampling.

- The auditor reviews the makeup of the supplemental data file and chooses a minimum of 5 cases per event type or code in the file to ensure a representative review of data that could contribute to a measure or measures.
- The total sample size should not exceed 50 cases per data source.

Errors identified during primary source verification

The data source 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 there is time to fix the errors and pull another sample, this can be done at the auditor's discretion. All validation steps must be completed by the required deadline.

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 supplemental data until PSV is complete and the source is approved. Work paper documentation should clearly show all validation steps.

NCQA Data Aggregator Validation

For data from an NCQA-Validated entity, the auditor must:

- Receive completed Roadmap documentation from the organization receiving the data (e.g., the health plan). The Roadmap must explain how data from the Responsible Party are transferred in an outbound file to the organization and what is done to the data. No documentation is required from the validated entity, unless it processes the validated CCD or FHIR.
- If the NCQA-Validated entity:
- Processes the validated CCD in any way (e.g., into a vendor file layout), see below about secondary source validation (SSV).
- Shares validated data formatted using FHIR® standards, these files cannot be processed to another data standard for data exchange. Processing the FHIR data to another data standard for exchange compromises the Validation status. For example, mapping the validated data from U.S. Core to the NCQA HEDIS Core Implementation Guide is permitted. However, mapping the validated data from U.S. Core to a flat file format is not permitted. Where mapping to the same data standard is performed, see below for SSV.

  For those processing in the approved way, they must also follow the criteria below, if applicable, which will be reviewed by a HEDIS Compliance Auditor:

  - Document mapping.
  - Document extract-transform-load (ETL) processes.
  - Maintain an original copy of the validated and conformed file (e.g., CCD, FHIR).
  - Auditors may perform SSV: Examine processed data back to the validated and conformed files. SSV does not include PSV back to the original source on any of these data sources. PSV is not to be performed.
- When exchanging data, the validated Responsible Party must produce an outbound file. There must be a distinction between the

Responsible Party (e.g., health system) and an entity using the data as standard supplemental (e.g., health plan). It is acceptable for a Responsible Party to share outbound files with certified measure vendors to run through their measure logic.

- Receive the final validation report of validated data cases and clusters, and the date when they were validated.
- Refer to NCQA's Data Aggregator Validation Directory to ensure that the NCQA validated entity is approved to share validated data. Organizations with a "Validated Data Stream" Status with an expiration date may share data and contribute to reducing audit burden. Organizations with a "Certified Data Partner" Status may not share data.

Data from ingestion sites or clusters that failed validation may not be shared as standard supplemental data. These data are considered nonstandard supplemental data and must be audited accordingly.

C-CDA and FHIR Guidance

For validating data from C-CDA or FHIR file (not human readable representation), the auditor must receive completed current year's *Supplemental Data* Roadmap documentation, which describes how the file is created and by whom (e.g., produced by the provider in the office and sent to the plan or created by the vendor), the validation process and how data are transmitted.

Once the auditor approves and validates the electronic clinical data, the data can be refreshed because data flows from EHRs continually; there is no stop date.

AI Guidance

Organizations utilizing supplemental sources involving AI (e.g., natural language processing, large language models) must document how the technology is used in the data collection process. The technology, workflows, internal validations, and ongoing governance of the process should be clear. Auditors must be able to identify the supplemental data that involve AI, in order to target validation requirements appropriately.

Electronic Clinical Data Systems (*ECDS)*

The author follows the appropriate validation method (depending on the ECDS data source: EHR, HIE/clinical registry, case management registry, administrative) to ensure that data are thoroughly reviewed and approved.

To be approved, ECDS data sources must follow the Guidelines for Measures Reported Using Electronic Clinical Data Systems (e.g., be accessible to the care team upon request) and meet applicable supplemental data requirements.

Impact reports are required for these measures..

Timeline requirements

…for nonstandard supplemental data

Data collection stops on or before the required PO or health plan deadline*. The auditor selects the sample and approves charts by the deadline.

…for standard supplemental data

The auditor works with the organization to review and approve data files by the validation deadline.

…for all supplemental data

Supplemental data sources must be identified and the applicable Roadmap documentation submitted by the January deadline. Any necessary updates to the

documentation may occur no later than the February deadline* or the supplemental data source cannot be used.

…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) 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.

…for ECDS data The auditor works with the organization to review and approve data sources by the validation deadline*.

*****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 finding

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 (IS review); therefore, one Licensed Organization's assessment of vendor's information systems is not transferable to another Licensed Organization. Only a final rate is portable and is allowed to be used by another organization.

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

- *NCQA recommends that Certified HEDIS Compliance Auditors and Licensed Organizations retain audit documentation for 7 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, it may destroy PHI, but must maintain all other work papers for at least 7 years. If PHI documents are needed during the 7-year period, the Licensed Organization must retrieve them from the client.*

Race and Ethnicity Data Validation

Auditors must confirm the following for race and ethnicity information used in reporting.

Source origin	The auditor should review the sources for race and ethnicity information. Any sources considered direct by the organization should be consistent with AMP guidance.
Data management	The auditor should: • Confirm the observed results of an organization's data management for race and ethnicity reporting are consistent with the organization's expected results. • Evaluate an organization's population distribution by race and ethnicity.

Auditors can determine the validation methods appropriate to meeting the requirements. Examples may include:

Observation/ interviews	Auditors discuss race and ethnicity information during the audit review. This may include demonstrations of information systems that collect or store these data (e.g., enrollment) and review of data management documentation (e.g., mappings, data source integration).
Secondary source verification	Auditors can compare race and ethnicity information loaded to a measure engine environment with the source data obtained by the organization.
Rate review	Auditors assess how an organization's population is categorized by race and ethnicity. Comparisons can be made across: • The Race/Ethnicity Description of Membership measure. • Distribution of initial populations by race and ethnicity for stratified measures. • Prior year measure results. • Available benchmarks.

Corrections are not required for any notable findings from rate review; however, the reporting organization must acknowledge the results as valid. Auditors are not expected to make bias determinations for a measure based on race and ethnicity stratification output.

Planning the Audit Review

The audit team

The auditor forms the audit team after an initial PO Roadmap review. At least one Certified HEDIS Compliance Auditor (CHCA) must complete the audit with the PO. The auditor may base the team structure and the visit length on the unique characteristics of the entity being audited.

Audit kick-off discussions

Early in the year or season, the lead auditor meets with the organization (in person, by phone or video conference) to introduce the audit team and state each team member's qualifications and disclose any work experience that could conflict with the audit.

The Licensed Organization, auditor and organization determine whether the audit will be conducted virtually or onsite. The lead auditor identifies potential issues, makes initial requests and discusses changes from previous years. During this meeting (or in another meeting), the audit team discusses the audit agenda and structure (e.g. complete all sessions in 1 day or over several days), resolves issues and ensures the availability of requested documentation and staff.

The auditor documents all meetings and audit sessions in the audit work papers and, at a minimum, list staff who attended and a summary of the discussion.

Audit Review

Audit reviews are a required part of the audit process. They allow the auditor to investigate issues identified in the PO Roadmap and assess information systems for data collection and management capabilities to enable reliable and valid reporting.

Audit reviews are performed by an audit team. At least one Certified HEDIS Compliance Auditor (CHCA) must be present to lead all audit review meetings, with no exceptions (other team members are not required to be CHCAs). The auditor keeps an audit attendance sheet, even when the audit is conducted remotely. Attendance sheets are not required to be signed but should list all participating staff and dates or participation. Audit reviews can occur in a single day or be conducted over several days, and can be in person or virtual.

The audit team interviews the PO's IS structure and processes, evaluates the organization's data management and assesses the measure-specific data capture with the staff responsible for selected measures. The team concludes the audit with a closing session and shares initial findings and additional documents or suggested corrective actions.

Additional audit review meetings may be required if an organization has delegated vendors or multiple facilities relevant to measure production. Meeting structure can depend on the size and composition of the reporting organization. The Licensed Organization and audit team determine how best to complete the audit.

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 AMP data management process.

The audit team explains how an audit is conducted: Reiterate the audit's purpose, the scope of the work, the required documentation, the interviews and tests it will perform. The team may schedule interviews and the auditors may receive or request additional information.

Audit Methods

The Certified HEDIS Compliance Auditor assesses the ability of the PO's systems and processes to produce reliable and accurate measure results during the audit and may include the following tools and techniques during the audit review.

Data Queries

All auditors *must* perform queries as part of every audit, but may determine the appropriate number based on the measures being reported. Queries should be tailored to the organization, to its data challenges and to its data and processes.

Queries may occur throughout the process. Requests for queries, the rationale for selection and results should be integrated into the work papers to support documentation of the audit.

Primary Source Verification

PSV confirms the validity of the source data described in the PO Roadmap—that the information from the primary source matches the output information used for AMP reporting. It addresses content and format, and traces the movement of data from the originating source through an organization's internal data

management to assess accuracy and completeness. This process is especially appropriate for electronic transmission of primary source data.

The auditor examines all media used to collect data, and reviews the processes for inputting, transmitting and tracking the data, confirming entry and detecting errors.

Data Layout Review

Forms and data (including electronic submissions or EDI) that typically contain AMP-relevant data and should be reviewed, when applicable:

- Prescription data.
- Registry or other supplemental data.
- Claims log (receipt and mailed payment tracking).
- Lab result forms or files.
- Supplemental data sources.

Data File Content Review

The auditor examines data files and reviews and validates 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 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 files and file access capability.

File Content Examination Methods

- Request transaction file output and compare to a sample set of source documents (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 initial population guidelines.

System or Program Review

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

Auditors are required to review relevant systems and processes during an audit (e.g., data and systems-oriented documents). It may be necessary, in the reporting process, to refer to documents examined by the auditor and to pinpoint evidence sources by document and section or subsection. The auditor records all organization documentation received and examined, and includes the record with the Final Audit Report.

Observation

As indicated by findings from queries, file reviews, PSV or system changes implemented between audit years, the audit team observes the systems and processes to ensure compliance with IS standards. At a minimum, the team ensures 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.

Process Review

The PO documents the processes for collecting, storing and reporting data. As indicated by findings from queries, file reviews and PSV, the auditor reviews the processes and explores how the PO ensures data integrity and completeness

Interviews

Throughout the audit, the audit team interviews PO staff to gain insight into the accuracy and reliability of the data and AMP results. Members of the audit team may ask staff to discuss or demonstrate how and where information is processed.

A list of attending interviewees and auditors must be maintained to indicate their participation in the audit, including the meeting and meeting date.

Discussion Topics and Recommended PO Personnel to Be Interviewed	
AMP team leader	• *Overall data management and reporting* • *Preliminary rate review and rationales*
Quality improvement director	• *Use of AMP information* • *Underlying data issues* • *Use of supplemental data*
Information systems (services)	• *All systems and databases supporting AMP reporting* • *Integration of supplemental data* • *Conduct queries*

Operations management director	• *Claims/encounter processing*

Data Completeness Findings and Impact Determination

Before the audit, the auditor reviews the PO Roadmap and identifies possible areas of concern. During 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 *BR assignment* must be supported by a determination of material bias.

IHA provides the auditor with Commercial HMO, Medicare Advantage and Medi-Cal Managed Care 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 without investigating whether data completeness issues affect the measure rate.

Closing Conference and Follow-Up Documentation

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

Within 10 business days of completing the audit, 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 audit review meeting sessions, with corrective actions and their completion dates.
- A list of additional documents needed to complete the Roadmap or the audit review, 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.

Follow-Up and Reporting

The nature of follow-up work depends on the outcome of the audit review meetings. During the audit review meetings, 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.

The follow-up phase may be an iterative process where 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 is forwarded by the PO, the auditor approves the final rates that reflect all data and produces 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 audit review findings.
- Initiate a new procedure and review its impact on reporting-year results.

Note: *Auditors must question the PO about* ***all*** *significant changes in performance following the bias determination thresholds (e.g., a (+/-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 2 weeks before data submission. On or before the completion date, the PO gives the results, supporting documentation and comments to the auditor, who determines if modification is necessary. If the PO declines to revise a noncompliant methodology, the auditor assesses 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 the auditor notes this 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 2 weeks before the data file submission to FinThrive HealthCare, Inc.*

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.

Rate/Result	Notes
0–XXX; R	*Reportable. A reportable rate was submitted for the 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	*Biased Rate. The calculated rate was materially biased. The auditor determines a result is not reportable due to material bias.*
SD	*Small Denominator. The PO calculated the result, but the denominator was too small (i.e., between 1 and 29) to report a valid rate.*
*NB**	*No Benefit. The health plan did not offer the health benefit required by the measure (e.g., pharmacy).*
NR	*Not Reported. The PO chose not to report the measure.*

***** *Benefits are assessed at the global level, not at the service level (refer to AMP MY 2026 Technical Specifications, General Guideline: Audit Results).*

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 measure results are collected but are not required to be audited.*
- *Ensure that appropriate health plan members are reviewed and compared with the AMP Contracts Roster.*

AMP Data Submission

Final Audit Opinion

At the close of the audit and within 30 days after the AMP reporting deadline, the auditor renders the Final Audit Opinion, which contains a Final Audit Statement, and submits it to NCQA and the PO.

Data submission file (rates and results)

IHA registers all AMP POs in November to determine their intent to self-report clinical measures for each MY, and provides information on data submission responsibilities to all self-reporting groups.

In January, IHA provides POs with a standard file format for submitting audited clinical quality data—the AMP Clinical Data File Layout. The file includes numerators, denominators, rates and audit results.

In May, the auditor signs off on and locks the PO's data submission file to FinThrive HealthCare, Inc., which includes all data elements defined in the data submission file.

Final date for submission

The final date for audited AMP data submission to FinThrive HealthCare, Inc. is the AMP reporting deadline listed in "Data Collection and Reporting Timeline" in the *Integrated Healthcare Association Align. Measure. Perform. (AMP) Programs:*

MY 2026 Program Guide.

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 [***PO's***] submitted measures for conformity with the MY 2026 AMP Technical Specifications. Our audit planning and testing was constructed to measure conformance to the MY 2026 AMP Technical Specifications for all measures presented at the time of our audit.

This report is [***PO's***] 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 MY 2026 Performance Report presents fairly, in all material respects, the PO's performance with respect to the AMP MY 2026 Technical Specifications.

Our examination was made according to AMP Audit 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, [***PO***] submitted measures were prepared according to the AMP MY 2026 Technical Specifications 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)

PO or Plan ID: _____ Submission ID(s): _____

Management Representation Letter

At the conclusion of the audit, each organization must sign a Management Representation Letter. Although the letter may be provided to the organization at any point in the audit the organization must complete and sign and return it to the auditor between April 26 and May 7. Auditors must maintain the signed copy of this letter in their audit work papers. Although it is the organization's responsibility to sign this letter, the Licensed Organization may help list the organization and submission IDs covered by the letter.

Management Representation Letter

Align. Measure. Perform. (AMP) MY 2026 Reporting

From Organization *(Health Plan or PO):* _____

To Auditor: _____

Audit Organization:_____

PO or Plan ID	Submission ID(s)

Note: *List all organization and submission IDs associated with the audit this letter represents. Add rows or an attachment 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 7, 2027.

We acknowledge our responsibility for the accuracy of the data in accordance with the 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.
- Organization has no knowledge of 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 initial 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 for 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

When the audit is complete, the auditor prepares a Final Audit Report that summarizes all audit activities for the PO. Audit details are contained in the Summary Report and the IS Assessment findings.

Within 30 days of the HEDIS reporting deadline, the auditor submits copies of the report to the PO and to NCQA. The report provides enough PO information for NCQA to evaluate whether results are supported and specific to the PO, and that the HEDIS Audit was conducted according to guidelines. NCQA evaluates each report and requires all noncompliant reports to be resubmitted, with corrections, within 7 business days of notification.

AMP REPORT CONTENTS	
Licensed Organization	• *Licensed Organization name.* • *Licensed Organization address.*
Audit Team Information	• *Name of auditor responsible for audit.* • *Role in audit.* • *Dates of involvement.*
PO Information	• *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	• *Scope of the audit indicating the measures reported.* • *Audit timeline with actual dates.* • *Auditor strategy and considerations (optional).*
Supplemental Data	• *List of all supplemental data contributing to reporting.* ***Note:*** *Each supplemental source must be cited as identified in the HEDIS Roadmap Clinical Data Inventory.* • *Identify any Data Aggregator Validation sources used.* • *Intended measure use.* • *Audit activities and approval status for each data source.* • *Data where AI was involved.* • *Indication that the organization did not use any supplemental data.*
Certification/ASCR	• *Indication that the PO used Certified Measures or ran ASCR.*
Final Audit Opinion	• *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 7 years. At a minimum, work papers must include the documents listed below.

The Licensed Organization maintains 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 7 years. If PHI documents are needed during the 7-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 client 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 3 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.
  - Audit data requests and subsequent deliveries.
  - Audit sessions dates and types (virtual or in person).
  - Audit activities such as document review and conference calls.
  - Follow-up documentation to the PO.
  - PO responses.
  - FinThrive Healthcare, Inc. submissions by the PO to the Licensed Organization.
  - Final FinThrive HealthCare, Inc. 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 emailed to the organization.

Audit Activities

- The PO Roadmap documentation:
  - 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 audit.
  - All requested documents.
  - All documents received from the PO (before the audit review) and auditor's notes and analysis for each, including if the issue is resolved or under discussion.
- Supplemental data findings:
  - A complete list of all sources, including type, process, measures affected, applicable incentives, issues and findings.
  - Source code review and results (if appropriate).
  - Policies and procedures documents.
  - Data mapping and integration assessment.
  - Sample files with format and content information (samples only).

  - Primary source verification notes and results with documentation of PSV (e.g., case number, result) so it can be re-created, if necessary.
  - Prior year's review and approval findings.
- 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 7 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.

Supporting Audit Activities

- A participant attendance log that includes the organization's name, the date, the audit review meeting sessions and the organization staff and auditors who participated in the audit.
- A complete record of audit 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 requested and collected.
  - Photos or scanned versions are acceptable.
  - Papers may be uploaded to the Licensed Organization's FTP site, but should be clearly marked as pertaining to the audit.

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.
  - A final timeline with actual completion dates.
  - 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., 3-year rate comparison, benchmark comparison).
  - Final rate submission tool, with PO and auditor notes and final auditor approval. Auditors must comment on all results outside the allowed bias determination guidelines. PO responses to auditor inquiries must be provided and included in the work papers.
  - Final, locked FinThrive HealthCare, Inc. 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 2026

APPENDIX 2

PO IS STANDARDS COMPLIANCE TOOL

(To be completed by the auditor.)

IS Standards Compliance Tool Instructions

Appropriate IS standards for all relevant information systems involved in reporting must be reviewed and addressed as part of the AMP audit. Auditors must thoroughly document the organization's compliance with each standard and the impact on measure reporting.

The tool below is an example of how the review can be documented, but Licensed Organizations may develop their own tools to track compliance. Note that some IS standards may be applicable to multiple information systems, and compliance must be tracked for each information system involved in reporting. For example, Administrative Data standards (IS A) apply to medical services and enrollment systems. NCQA does not require standards to be addressed in all three audit phases, but there must be evidence that required reviews were performed and audit timeline requirements were met.

KEY: S = Significant impact on reporting **M** = Minimal impact on reporting **N** = No impact on reporting

Note:

- *If the reporting impact is S or M, record the recommended corrective actions.*
- *Onsite review may be in person or virtual.*

IS Standards

Standard		Document for Each System Where the Standard Is Applicable	AUDIT ACTIVITIES			AMP IMPACT
			Pre-Audit Review and Results	Audit Review and Results	Post-Audit Review and Results	S, M, N Comments
IS R DATA MANAGEMENT AND REPORTING (IS 5.0 & IS 6.0)						
IS R1	*The PO's data management enables measurement.*	*(example: ABC PO)*				
IS R2	*Data extraction and loads are complete and accurate.*	*(example: ABC PO)*				

Standard		Document for Each System Where the Standard Is Applicable	AUDIT ACTIVITIES Pre-Audit Review and Results	AUDIT ACTIVITIES Audit Review and Results	AUDIT ACTIVITIES Post-Audit Review and Results	AMP IMPACT S, M, N Comments
IS R3	*Data transformation and integration is accurate and valid.*	*(example: ABC PO)*				
		(example: ABC vendor)				
IS R4	*Data quality and governance are components of the PO's data management.*	*(example: ABC PO)*				
		(example: ABC PO)				
IS R5	*Oversight and controls ensure correct implementation of measure reporting software.*	*(example: ABC PO)*				
		(example: ABC vendor)				
IS R6	*Cybersecurity practices are in place to promote protection and resiliency of the systems and data used for measurement.*	*(example: ABC plan)*				
IS C CLINICAL AND CARE DELIVERY DATA						
IS C1	*Data capture is complete.*	*(example: Boston Accountable Care)*				
		(example: At Home Health)				
		(example: COVID Vaccination)				
		(example: Prior Auth Appeals)				
IS C2	*Data conform with industry standards.*	*(example: Boston Accountable Care)*				
		(example: At Home Health)				
		(example: COVID Vaccination)				
		(example: Prior Auth Appeals)				
IS C3	*Transaction file data are accurate.*	*(example: Boston Accountable Care)*				

Standard		Document for Each System Where the Standard Is Applicable	AUDIT ACTIVITIES Pre-Audit Review and Results	Audit Review and Results	Post-Audit Review and Results	AMP IMPACT S, M, N Comments
		(example: At Home Health)				
		(example: COVID Vaccination)				
		(example: Prior Auth Appeals)				
IS C4	*PO confirms ingested data meet expectations for data quality.*	*(example: Boston Accountable Care)*				
		(example: At Home Health)				
		(example: COVID Vaccination)				
		(example: Prior Auth Appeals)				
IS A ADMINISTRATIVE DATA						
IS A1	*Data conform with industry standards and measure requirements.*	*(example: medical services system)*				
		(example: enrollment system)				
IS A2	*Data are complete and accurate.*	*(example: medical services system)*				
		(example: enrollment system)				
IS A3	*Membership information system enables measurement.*	*(example: medical services system)*				
		(example: enrollment system)				

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.
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 persons (see *initial 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	Designations assigned by the HEDIS®[1] Compliance Auditor indicating the report status of each measure.
bias (degree of bias)	Degree of error. AMP rate measures are reported using a 95% 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.
C-CDA	Consolidated clinical document architecture. A data standard for exchanging clinical documents (e.g., discharge summaries, progress notes, history and physical) electronically using XML.
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	Determine the denominator 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.
concurrent audit	Evaluation of methods and data during the data collection period. AMP Audit

[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

	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 *Biased Rate (BR)*.
database	Data collected and organized in a computer file for ease of expansion, updating and retrieval.
data consolidation	A combination of data from multiple sources, such as multiple electronic sources or electronic and medical record sources.
data extraction	Collect data from medical records or from electronic and automated systems.
data integration	Combining data from multiple sources, with additional steps to ensure that duplicate data are removed and remaining data are refined.
data integrity	Data that have not been altered or destroyed.
data reliability	A measure of data consistency based on reproducibility and an estimation of measurement error.
delegate	A PO or health plan gives an 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.
EDI	Electronic data interchange. 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.
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. AMP Technical FAQ are posted to the IHA website (www.iha.org), as needed.
FHIR®	Fast Healthcare Interoperability Resources. A specification standard that supports electronic exchange of structured and standardized data. Resources are built from data types that define common, reusable patterns of elements and share a common set of metadata.
FQHC	Federally Qualified Health Center. Only FQHCs are considered primary care

	practitioners. This must be reviewed and approved by an auditor. To be certified as an FQHC, an entity must meet any one of the following criteria: • 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. For certification as an FQHC, the entity must meet all of the following criteria (in addition to one of the criteria above): • 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.
HMO	Health maintenance organization. An organized health care system that is accountable for both financing and delivering a broad range of comprehensive health services to an enrolled population. An HMO is accountable for assessing access and ensuring quality and appropriate care. Members must obtain all services from affiliated practitioners and must usually comply with a predefined authorization system to receive reimbursement.
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.
initial population	The initial population includes all members who satisfy attribution criteria, including age, continuous enrollment, allowable gap, benefit, and event criteria.
industry standard code	A code used by the majority of health care facilities and providers. AMP measures use these codes in the specifications (CPT, ICD-10-CM, CMS1500 place of service, UB type of bill, revenue codes).
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.
master data management	Policies and procedures for governance of quality measure data; specifically, defining creation of a master data file for quality reporting. An organization must

	use a master data management process to verify data integrity across the multiple data systems used in reporting, ensuring consistent identification and classification of data elements and standardized data reconciliation procedures. Reconciliation procedures include, but are not limited to, validation, deduplication and reliability checks to correct latent data errors related to either the acquisition of encrypted data or ETL (extract, transform and load) integration of data into a master file.
measurement year	The year that the health plan or PO is evaluating through AMP measures, often referred to as the "data year."
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 AMP.
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	Provider 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.
POS	Point of service. An 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 *Childhood Immunization Status* 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.
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 HMO/POS, Medicare Advantage, Medi-Cal Managed Care.
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 AMO is reported. 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.
RHC	Rural Health Clinic. Only certified RHCs are considered PCPs. To be certified as an RHC, the entity must meet CMS requirements to qualify for payment via an all-inclusive rate for medically necessary primary health services and qualified preventive health services furnished by an RHC practitioner and must be reviewed and approved by an auditor.
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 event or documentation that supports a 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 is available on IHA.org.*

Data Quality Measures

ENRST	Encounter Rate by Service Type
RDM	Race/Ethnicity Description of Membership

Clinical Quality Measures

Behavioral Health & Substance Use

DSF-E	Depression Screening and Follow-up for Adolescents and Adults

Cardiovascular Conditions

BPC-E	Blood Pressure Control for Patients With Hypertension
CBP	Controlling High Blood Pressure
PDC-RASA	Proportion of Days Covered by Medications: Renin Angiotensin System
PDC-STA	Proportion of Days Covered by Medications: Statins

Diabetes

PDC-DR	Proportion of Days Covered by Medications: Diabetes All Class
GSD	Glycemic Status Assessment for Patients With Diabetes
EED	Eye Exam for Patients With Diabetes
KED	Kidney Health Evaluation for Patients With Diabetes
SUPD	Statin Use in Persons With Diabetes

Musculoskeletal Conditions

OMW	Osteoporosis Management in Women Who Had a Fracture

Prevention and Screening

WCV	Child and Adolescent Well-Care Visits
W30	Well-Child Visits in the First 30 Months of Life
CIS-E	Childhood Immunization Status

IMA-E	Immunizations for Adolescents
CHL	Chlamydia Screening
CCS-E	Cervical Cancer Screening
BCS-E	Breast Cancer Screening
COL-E	Colorectal Cancer Screening
TRC	Transitions of Care

Maternity

PPC	Prenatal and Postpartum Care
PRS-E	Prenatal Immunization Status