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

Audit Review Guidelines
Measurement Year 2021

Released November 2021

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Introduction

Introduction

Background

The clinical quality measures can be found in the Integrated Healthcare Association California Align. Measure. Perform. (AMP) Programs: Measurement Year (MY) 2021 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 Physician Organization (PO) performance. The audit review of the clinical measures is based on NCQA's HEDIS Compliance Audit™ program. NCQA staff have worked with AMP participants since 2003 to incorporate the relevant components of the HEDIS Compliance Audit and to adapt policies and procedures where necessary.

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

Contents of This Manual

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

- New language is in red font.
- Removed references to source code review and core set selection.
- Deleted IS 3.0 Practitioner Data.
- Update Audit Timeline.
- Revised IS 4.6 under IS 4.0 Supplemental Data—Capture, Transfer and Entry.
- Removed references to retired measures and added new measures.

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 at https://my.ncqa.org/.

FAQs and Policy Updates

The FAQs and policy updates are posted on the IHA website (www.iha.org) on the 15th of each month.

Reporting Hotline for Fraud and Misconduct

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

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

How to Report

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

AMP Audit 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 Certified Auditor may request additional detailed information about the processes for generating measure results by PO. Electronic copies of the Roadmap are available from your NCQA Licensed Organizations each November.

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 a completed Roadmap section 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 PO master list to ensure that all groups are reported.
- Ensure that the rate column equals the numerator column/denominator column.
- Ensure that each rate field has five digits after each decimal and that numbers have not been rounded.
- Ensure that no rate is more than 100%.
- Compare AMP total enrollment to the total plan enrollment.
- Perform year-over-year comparisons of total enrollment.
- Cross check total enrollment data with ENRST.

- Check each AMP ID/Sub ID 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 in Women).
- For all measures assessing the same denominator population across multiple numerator events (e.g., Comprehensive Diabetes 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.
- 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 2021 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	*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 did not report the measure (may only be used only 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 AMP MY 2021 Technical Specifications, *General Guidelines 28: Required Benefits*).

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, TransUnion HealthCare, is shown on the "Data Collection and Reporting Timeline" in the *AMP Program Guide.* The timeline also shows the date when TransUnion HealthCare provides the standard format for submitting data. The auditor approves the health plan's data submission file to TransUnion HealthCare, including all data elements defined in the data submission file specifications.
Final 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 2021 submitted measures of [**insert health plan's name here**] for conformity with the Integrated Healthcare Association Align. Measure. Perform. Programs: AMP MY 2021 Technical Specifications and the AMP MY 2021 Audit Review Guidelines. Our audit planning and testing were constructed to measure conformance to the AMP MY 2021 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 2021 AMP Audit Manual. Our examination included procedures necessary to obtain reasonable assurance that the MY 2021 submitted measures were generated according to the AMP MY 2021 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 2021 submitted measures of [**insert health plan's name here**] were prepared according to the AMP MY 2021 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. NCQA requires audit documentation and work papers to be retained for seven years after the reporting deadline.

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

For a complete list of required documents, refer to HEDIS MY 2021 Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.

AMP Audit Standards for POs

Overview

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

This section includes the standards 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.

Standards are divided into two sections.

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

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

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

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

Information System Standards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Measure Certification

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

IS 2.0 Enrollment Data—Data Capture, Transfer and Entry

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

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

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

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

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

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

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

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

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

Measure Certification

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

IS 4.0 Supplemental Data—Capture, Transfer and Entry

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

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

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

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

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

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

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

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

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

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

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

IS 4.6 NCQA-validated data resulting from the Data Aggregator Validation (DAV) program met reporting requirements.

- Only DAV validated data streams are accepted as standard supplemental data.
- Policies, procedures and log forms for data receipt ensure accuracy and completeness and verify that the organization has mechanisms for transferring information to the appropriate location within the organization.
- Proper control of transmission by logs, record count verification or other mechanisms to ensure that all data are received.
- There are documented mappings, Extract, Transform, Load (ETL) processes and so on, if the validated DAV CCD file is processed for integration for AMP reporting. Mapping and translation must be verified to the original validated CCD.

Measure Certification

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

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

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

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

IS 5. 2 Data transfers to AMP repository from transaction files are accurate.

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

IS 5.3 File consolidations, extracts and derivations are accurate.

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

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

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

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

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

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

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

Measure Certification

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

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

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

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

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

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

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

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

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

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

Measure Certification

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

The PO and auditor must ensure that the appropriate version of the certified measure was used to produce AMP results by reviewing and validating the unique measure identifier (GUID).

Measure Determination Standards

HD 1.0 Denominator Identification

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

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

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

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

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

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

Measure Certification

The auditor must review and validate the Certified Measure's unique identifier to ensure that the appropriate version of the measure was used for all organizations reporting AMP measures.

HD 2.0 Numerator Identification

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

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

Measure Certification

The auditor must review and validate the Certified Measure's unique identifier to ensure that the appropriate version of the measure was used for all organizations reporting AMP measures.

HD 3.0 Algorithmic Compliance

HD 3.1 Rate calculations are arithmetically correct and precise.

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

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

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

Measure Certification

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

HD 4.0 Outsourced or Delegated AMP Reporting Function

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

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

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

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

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

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

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

Measure Certification

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

AMP Audit Review for POs

Policies and Procedures

Who Must Undergo an Audit Review?

Any organization that produces AMP data must undergo an AMP Audit Review (an audit is not required for AMP Commercial ACOs). 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 2021 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. NCQA posts lists of Licensed Organizations and Certified Auditors on its website (https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/).

Audit Monitoring and Oversight

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

Program goals	• Ensure that audits are conducted in a manner consistent with NCQA specifications, standards and policies and procedures. • Ensure that the rigor of audits is consistent across all Licensed Organizations and Certified Auditors. • Identify opportunities for improvement (design and implementation).
Performance categories:	NCQA evaluates the consistency of audit practices across organizations and auditors by observing individual Certified Auditors as they conduct Audits at health plans and POs and reviewing work papers for evidence that audits conform with NCQA methodology and documentation standards. NCQA assesses performance by Certified Auditors and Licensed Organizations in five major categories.
1. Audit Process	Audit strategy, team selection, preparation and initial assessment.
2. IS Assessment	Evaluate information systems and processes used to collect and report AMP measures.
3. Measure Compliance and Preliminary Rate Review	Determine compliance with AMP technical specifications and evaluation of preliminary rates.
4. Reporting	Conclude audit findings and final rate review for rendering a final audit opinion.
5. Work Papers	Documentation and evidence that support the audit activity and decisions in 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.
- 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) to NCQA for all identified areas of improvement.

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

Portability of Opinion

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

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

Confidential communication

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

Disclaimer

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

Audit Appeal and Grievance Procedures

Licensed Organization's responsibility

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

The Licensed Organization notifies the NCQA Assistant Vice President of Measure Collection and Audit, in writing, within two business days of the filing of:

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

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

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

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.

A full list of measures in the scope of AMP Measure Certification can be found in *Appendix 4: 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 2021 measure certification testing process are listed on the NCQA website (https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/measure-certification/). The deadline for vendors to complete AMP MY 2021 measure certification is November 1, 2021.

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 2021 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.
- **Follow-Up and Reporting:**
  - Documents and Corrective Actions.
  - Audit Results.
  - Data Submission.
  - Management Representation Letter.
  - Final Audit Report.

Audit Validation Activities

The sections in this chapter describe audit requirements. 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 audit timeline, especially for activities with non-negotiable dates.

- Contract Execution.
- Roadmap Assessment.
- Supplemental Data Validation.
- 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 a timeline. The organization selects and contracts with an NCQA Licensed Organization to conduct the audit. All Licensed Organizations employ or contract with Certified Auditors and select an audit team for the organization. NCQA lists Licensed Organizations on its website (https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/licensed-organizations/).

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

Negotiate a timeline

During the contracting phase, the PO and the Licensed Organization negotiate an audit timeline. To guide this negotiation, NCQA has set completion dates for several audit milestones that have firm deadlines. When necessary, the Licensed Organization and auditor may clarify deadlines for certain tasks to ensure successful completion. Organizations should work closely with their auditor to complete all tasks by the deadlines, and we encourage completion of activities earlier than the deadline when possible.

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

Activity or Milestone	PO Deadline	Health Plan Deadline
PO contracts with an NCQA-Licensed Organization.	October 1, 2021	
Measure Certification deadline for AMP measures.	November 1, 2021	
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 starting November 1 as long as the completed Roadmap section has been submitted.*	November 1, 2021	
Audit reviews begin (onsite or virtual). *Audit reviews are not to begin prior to the start of the reporting year and receipt of the Roadmap.*	After January 1	
PO submits the completed current year's Roadmap to the auditor. *The auditor must receive the Roadmap by the January deadline or at least two weeks before the site visit, whichever date is earlier.*	By January 31, 2022	
Supplemental Data Collection Deadline. Organization submits all documentation, including Roadmap Sections 4 and 4a and all applicable attachments, and stops all nonstandard data collection and entry. *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 completed Roadmap section by this date cannot be used for AMP reporting.	February 11, 2022	March 1, 2022
Supplemental Data 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 11, unless the PO finished all supplemental data processes, collection and entry. There are *no exceptions!*	March 11, 2022	
Organization submits preliminary rates to the auditor for review. *Auditors should review preliminary rates based on the current year's specifications.*	March 25, 2022	
Supplemental Data Validation Deadline. Auditor finalizes approval of *all* supplemental data for **health plans.** PSV for nonstandard supplemental data must not occur prior to March 1 unless the health plan finished all supplemental data processes, collection and entry. *No exceptions!*		March 31, 2022
Supplemental Data to Health Plans: AMP health plans receive the audited supplemental data files and audit results from the PO.	March 31, 2022	
Preliminary rate review feedback completed. *This date is the latest when this review should be completed. NCQA encourages preliminary rate review to take place earlier in the audit process.*	April 8, 2022	
Audit (onsite or remote) visits completed.	April 15, 2022	
Submission Files to Auditors: Self-reporting POs and health plans send submission files to auditors.	April 25, 2022	
Auditor Locked AMP Results: Self-reporting POs and health plans submit auditor-locked AMP clinical results to TransUnion HealthCare. Health plans must submit results for all clinical measures for each contracted PO with a signed AMP Consent to Disclosure Agreement. *The Management Representation Letter is due.* *[Audit not required for AMP Commercial ACO]*	May 6, 2022	

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.	May – June 2022*	
Appeals Hearing: The AMP Appeals Panel reviews and decides on all appeals to change quality results, if needed.	June 2022*	
Licensed Organizations submit Final Audit Reports to NCQA.	July 15, 2022*	
Resubmission of Auditor-Locked AMP Results: Self-reporting POs and health plans submit auditor-locked AMP clinical results to TransUnion HealthCare, if needed.	July 2022*	

**Exact dates for these activities will be included in the Final MY 2021 Program Guide to be released on December 15, 2021.*

Roadmap Assessment

The PO Roadmap

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

NCQA requires organizations to give the auditor a current year's PO Roadmap *every year* (the MY 2021 PO Roadmap must be submitted for MY 2021; a copy of the MY 2020 Roadmap is not acceptable). The Roadmap must be received by the auditor by the January 31 deadline or at least two weeks before the site visit, whichever is earlier. Auditors should encourage the PO to complete the Roadmap sooner, when possible. Completed supplemental data Roadmap sections and attachments not submitted to the auditor by the February 11 (POs) or March 1 (health plans) deadline cannot be used for AMP reporting.

At the end of the audit process, each organization must sign a management representation letter (an electronic version is acceptable). The letter may be provided to the organization at any point in the audit; however, the organization must complete and sign it and return it to the auditor between April 25 and May 6, after the auditor completes final rate validation. Auditors must maintain the signed copy of this letter in their audit work papers.

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

Timing

The auditor uses the completed PO Roadmap to:

- Plan audit activities.
- Identify areas that require clarification.

Supplemental Data Validation

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

Audit requirements

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

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

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

Auditors must document 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.

…for all supplemental data

The auditor reviews Section 4 or Section 4a of the Roadmap 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 or services were performed and not merely ordered.

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

- Reviewing measure rates before and after loading each supplemental data file.
- Comparing 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 that:
  - Forms or tools used to collect data elements according to the measure specifications.
  - Appropriate staff are rendering services, if measures have a requirement for provider type. Documentation of the practitioner’s NPI/

TIN is not required; however, documentation of NPI/TIN, along with date, name and signature, is preferred.

- Rater-to-standard or interrater reliability quality control testing protocols, standards and reports support reporting.
- Data abstraction tools meet audit standards.
- Guidance for translating free text to standard codes complies with clinical coding standards and AMP specifications.
- Data entry or uploading processes for adding nonstandard supplemental data to the repository are correct.

Additional steps to complete the evaluation are at the auditor's discretion.

- Ensures that data come from acceptable sources.
- Conducts PSV every year, without exception, on all nonstandard files. Validation of nonstandard supplemental data, including PSV, may not be performed before ***all*** of the following conditions are met, and they must be documented:
  - It is after November 1 of the measurement year (refer to the Audit Timeline).
  - The Roadmap has been submitted (each Section 4 is complete).
  - Supplemental data collection has stopped .

  PSV requires the following steps:
  - The organization finishes collecting the data and closes the files for input.
  - The auditor creates a random, systematic or stratified sample using acceptable statistical methods.
  - Random samples may be generated in Excel.
  - Systematic samples may be selected with a skip interval.
  - Stratified samples may be used to ensure that all types of events are included in the sample, when a more random method would likely omit low-volume events.
  - All samples are auditor selected. Although the organization's sample may not be used, any PSV record that overlaps with records in the auditor's sample may be used. *Auditors may share PSV samples, but must validate the samples independently and provide their own results.*
  - The auditor gives the list of sampled events to the organization, and the organization submits the proof-of-service (POS) documentation for each event.
    - The auditor performs PSV using the POS supplied for each event in the sample and determines:
      - That the source of POS is acceptable as described in the AMP Manual. That the POS document was created before January 1 of the reporting year.
      - That the POS document contains all the elements required for the measure.
      - That the POS document contains appropriate and correct data elements (e.g., dates, procedure, diagnosis, provider information, member information).

- That there were no errors (e.g., mapping strategies were based on standard codes, there were no exclusions for conditions that may change).

POS examples

Proof-of-Service Documents
• Laboratory and radiology reports. • Sections of the member's legal health record showing service or assessment. – PDFs printed from an EHR are not acceptable POS documents. These are programmatically created, human readable CCDs. Unless it can be demonstrated that the PDF was not programmatically created and is a screen shot, an actual screen shot/screen grab must be provided. • Must be recorded, signed and dated by the rendering provider.

Sample sizes for primary source verification

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

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

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

NCQA DAV data

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

- Receive a completed current year's Roadmap Section 4 from the reporting entity using the data. The Roadmap must explain how data from the validated DAV entity is transferred to the reporting entity and what the entity does to the data. This is completed by the health plan; no documentation is required from the DAV entity, which has already been validated.
  - If the reporting entity processes the validated CCD in any way after receipt, the auditor must validate the file back to the original validated CCD to ensure that no data were changed.
- Receive the final validation report that indicates the validated data clusters and the date when they were validated.

If an NCQA-validated DAV entity includes data from an unvalidated data cluster, the auditor must validate the data, following the nonstandard supplemental data guidelines, before the data can be used for AMP reporting. The auditor may not perform PSV on any validated data files.

CCDs

For validating data from a CCD, the auditor must receive a completed current year's Supplemental Data Roadmap section that describes how the CCD 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.

PSV is required to validate CCD accuracy. To do this, plans go back to each unique EHR to retrieve screen shots of the services being validated. PDF images printed from the EHR are not acceptable because these are merely CCDs in a human readable/viewable format. This level of validation is required for at least the first year or the first submission by the EHR, but may continue in subsequent years until the auditor is satisfied that data are accurate and reliable and have not changed.

If the auditor has performed PSV in previous year(s) and is confident approving the data source without additional PSV in subsequent years, the auditor must document the decision in the audit work papers (e.g., no changes to processes or systems, CCDs used for the same set of measures).

Timeline requirements

Once validated and approved by the auditor, CCDs can be refreshed.

…for nonstandard supplemental data

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

…for standard supplemental data

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

…for all supplemental data

Supplemental data sources must be identified and the Roadmap sections completed by the 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.

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

Portability of audit findings

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

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

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

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

Auditor approval summary

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

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

Note

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

Planning the Audit Review

The audit team

After an initial PO Roadmap review, the auditor forms the team. At least one Certified HEDIS Compliance Auditor (CHCA) must complete the audit with the plan. 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 should determine whether the audit will be conducted virtually or onsite. The lead auditor identifies potential issues and makes initial requests and discusses changes from previous years. During this or another meeting, the audit team discusses the audit agenda and structure (e.g. complete all sessions in one day or over the course of several days), resolves issues and ensures the availability of requested documentation and staff.

The auditor must document all meetings and audit sessions in the audit work papers and, at a minimum, list staff who attended and summarize the discussion.

Audit Review

The audit review, a required part of the audit process, allows the auditor to investigate issues identified in the PO Roadmap, observe systems used to collect and produce measure data and query and review the data used for HEDIS reporting. The review may occur in a single day or may be conducted over several days and may be in person or virtual.

The audit review is performed by an audit team. At least one CHCA must be present to lead all audit review sessions—with no exceptions—but other team members are not required to be CHCAs. The auditor must keep a dated audit attendance sheet, even when the audit review is conducted remotely. Attendance sheets indicate staff who participated in specific sessions of the audit review and the dates. Sheets are not required to be signed.

The Audit

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

Opening Meeting

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

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

Audit Methods

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

Interviews

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

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

Discussion Topics and Recommended PO Personnel to Be Interviewed	
AMP team leader	• Overall data collection, data integration 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

Interview questions

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

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

Primary source verification

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

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

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

Forms and data to review

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

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

Process review

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

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

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

System or program review

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

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

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

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

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

Observation

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

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

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

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

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

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

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

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

Data file content review

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

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

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

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

File content examination 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 eligible population guidelines.

Data queries

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

Data Completeness Findings and Impact Determination

Before the 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 *Biased Rate (BR) designation* must be supported by a determination of material bias.

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

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

Closing Conference and Follow-Up Documentation

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

Within 10 business days of 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 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 sessions. During the audit review, the CHCA usually finds issues that the PO can resolve before the final rates are submitted and the Final Audit Report is issued. The auditor reviews and re-audits the corrective actions and determines if they justify a change in the initial findings or audit results. The audit team sends the audit results to the PO and NCQA in the reporting phase of an NCQA AMP Audit Review.

Corrective Actions and Reassessment

Improving accuracy and reliability

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

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

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

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

Review for sufficient corrective action

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

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

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

Audit Results

PO results

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

Rate/Result	Notes
0–XXX	*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 to report a valid rate (denominator between 1 and 29 members): a. For clinical measures, when the denominator is <30. b. For Total Cost of Care (TCOC) when the denominator is <200-member years. Small denominator criteria are used for public reporting only. c. For All Cause Readmissions (PCR) when the denominator (index hospital stays) is <30. Small denominator criteria are used for public reporting only. For all risk-adjusted utilization measures, except PCR, when the denominator is <150. d. For utilization measures that count member months, when the denominator is fewer than 360 member months.
*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 2021 Technical Specifications, *General Guideline 28: Required Benefits*).

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 PO Master File.*

AMP Data Submission

Final Audit Opinion

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

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 the PO's data submission file to TransUnion HealthCare, which includes all data elements defined in the data submission file.

Final date for submission

The final date for audited AMP data submission to TransUnion HealthCare is the AMP reporting deadline listed in "Data Collection and Reporting Timeline" in the *Integrated Healthcare Association Align. Measure. Perform. (AMP) Programs: MY 2021 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 2021 AMP Technical Specifications. Our audit planning and testing was constructed to measure conformance to the MY 2021 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 2021 Performance Report presents fairly, in all material respects, the PO's performance with respect to the AMP MY 2021 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 2021 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 process, each organization must sign a management representation letter. The letter may be provided to the organization at any point in the audit; however, the organization must complete and sign the document and return it to the auditor between April 25 and May 6, after the auditor completes final rate validation. 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 License Organization may help list the applicable organizations and submission IDs covered by the letter.

Management Representation Letter
Align. Measure. Perform. (AMP) MY 2021 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 6, 2022.

We acknowledge our responsibility for the accuracy of the data in accordance with the MY 2021 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 eligible population (e.g., if an organization's Medi-Cal Managed Care submission should include dual-eligible members, make sure these members have been included).
  - Only appropriate members were excluded (e.g., ASO members, if there is a no-touch contract in place).
  - All required measures were reported.
  - Rates were produced using certified measure logic 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 Contents

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

AMP REPORT CONTENTS	
Licensed Organization	• Licensed Organization name. • Licensed Organization address.
Audit Team Information	• Name of auditor responsible for audit. • Role in audit. • Dates of involvement. • Years of audit experience.
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 files and types. • Intended measure use. • Audit activities and approval status for each data source. • Indication that the organization did not use any supplemental data.
Certification/ASCR	• Indication that the PO used Certified Measures.
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 seven 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 seven years. If PHI documents are needed during the seven-year period, the Licensed Organization must retrieve them from the client.

Note

- *All Licensed Organizations are required to provide **either:***
  - *Access to their full email system, **or***
  - *All 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 three years.
– Copies of all current audit contracts or letters of intent with required NCQA language for indemnification and appeals processes.
– Copies of all contracts with independent auditors showing current and historic relationships between the Licensed Organization and the auditor, and the scope of work.

- An audit timeline that includes negotiated and actual dates for at least:

– Opening meetings or conference calls.
– Receipt of PO Roadmap.
– 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.
– TransUnion HealthCare submissions by the PO to the Licensed Organization.
– Final TransUnion HealthCare submissions.

- Audit correspondence (email and phone):

– All correspondence among team members.
– All correspondence between auditors and the PO.
– All announcements from vendors to clients pertaining to Measure Certification.

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

Audit Activities

- The PO Roadmap papers:

– The PO Roadmap executed by the organization and vendor, if applicable.
– A paper or electronic copy of the Management Representation letter, with the appropriate signature and date.
– Auditor notes from reviewing the PO Roadmap, including all preliminary issues and items to discuss before or during the 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 database findings:

– A complete list of all databases, 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 three years.*

- Interim versions of the IS standards compliance tool.
- Audit correspondence (email):

- Key correspondence among team members.
- Key correspondence between auditors and the PO.
- All announcements from vendors to clients pertaining to measure certification.

Supporting Audit Activities

- A participant attendance log that includes the organization's name, the date, the 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. Alternatively, papers may be uploaded to the Licensed Organization's FTP site and 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., three-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 TransUnion HealthCare submission.
- Final Audit Report.
- Signed Management Representation letter for all audits performed.
  - Audit correspondence (email):
- All correspondence among team members.
- All correspondence between auditors and the PO.

Appendix 2

PO IS Standards Compliance Tool

Released November 2021

APPENDIX 2

PO IS STANDARDS COMPLIANCE TOOL

(To be completed by the auditor.)

IS Standards Compliance Tool Instructions

All IS standards 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 LOs may develop their own tools to track compliance. Although it is not required to clearly address each standard in all three audit phases there must be evidence that required reviews were performed and audit timeline requirements were met.

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	AUDIT ACTIVITIES			AMP IMPACT
	Pre-Audit Review and Results	Audit Review and Results	Post-Audit Review and Results	S, M, N Comments
IS 1.0 Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry				
IS 1.1 Industry standard codes (e.g., ICD-10-CM, ICD-10-PCS, CPT®, HCPCS) are used and all characters are captured.				
IS 1.2 Principal codes are identified and secondary codes are captured.				
IS 1.3 Nonstandard coding schemes are fully documented and mapped back to industry standard codes.				

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Standard	AUDIT ACTIVITIES			AMP IMPACT
	Pre-Onsite Review and Results	Onsite Review and Results	Post-Onsite Review and Results	S, M, N Comments
IS 1.4 Standard submission forms are used and capture all fields relevant to AMP measure reporting. All proprietary forms capture equivalent data. Electronic transmission procedures conform to industry standards.				
IS 1.0 Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry				
IS 1.5 Data entry and file processing procedures are timely and accurate and include sufficient edit checks to ensure accurate entry and processing of submitted data in transaction files for AMP measure reporting.				
IS 1.6 The PO continually assesses data completeness and takes steps to improve performance.				
IS 1.7 The PO regularly monitors vendor performance against expected performance standards.				
IS 2.0 Enrollment Data—Data Capture, Transfer and Entry				
IS 2.1 The PO has procedures for submitting AMP-relevant information for data entry. Electronic transmissions of membership data have necessary procedures to ensure accuracy.				
IS 2.2 Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.				
IS 2.3 The PO continually assesses data completeness and takes steps to improve performance.				
IS 2.4 The PO regularly monitors vendor performance against expected performance standards.				

Standard	AUDIT ACTIVITIES			AMP IMPACT
	Pre-Onsite Review and Results	Onsite Review and Results	Post-Onsite Review and Results	S, M, N Comments
IS 4.0 Supplemental Data—Capture, Transfer and Entry				
IS 4.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes.				
IS 4.2 The PO has effective procedures for submitting AMP measure-relevant information for data entry. Electronic transmissions of data have checking procedures to ensure accuracy.				
IS 4.3 Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.				
IS 4.4 The PO continually assesses data completeness and takes steps to improve performance.				
IS 4.5 The PO regularly monitors vendor performance against expected performance standards.				
IS 4.6 NCQA-validated data resulting from the Data Aggregator Validation (DAV) program met reporting requirements.				
IS 5.0 Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity				
IS 5.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented.				
IS 5.2 Data transfers to AMP repository from transaction files are accurate.				
IS 5.3 File consolidations, extracts and derivations are accurate.				

Standard	AUDIT ACTIVITIES			AMP IMPACT
	Pre-Onsite Review and Results	Onsite Review and Results	Post-Onsite Review and Results	S, M, N Comments
IS 5.4 Repository structure and formatting is suitable for measures and enable required programming efforts.				
IS 5.5 Report production is managed effectively and operators perform appropriately.				
IS 5.6 The organization regularly monitors vendor performance against expected performance standards.				
IS 6.0 Data Integration and Reporting—Accurate AMP Reporting, Control Procedures That Support AMP Reporting Integrity				
IS 6.1 Data transfers to AMP measure vendor repository from AMP repository are accurate.				
IS 6.2 Report production is managed effectively and operators perform appropriately.				
IS 6.3 AMP measure reporting software is managed properly with regard to development, methodology, documentation, version control and testing.				
IS 6.4 The organization regularly monitors vendor performance against expected performance standards.				

Appendix 3

Glossary

APPENDIX 3
GLOSSARY

accuracy	The extent to which recorded data (on medical records, forms and computer databases) are error-free and reflect the defining events. Error sources are miscoding, misrepresenting facts, maintaining out-of-date findings, recording data for the wrong person, data entry and computer programming errors.
administrative database	Automated data, including claims and encounter systems used by the PO or health plan to manage the delivery of health services to members.
administrative method	Requires the PO and health plan to identify a measure's denominator and numerator, using transaction data or other administrative databases. The denominator comprises all eligible members (see **eligible population**). The PO reports a rate based on all members who meet the denominator criteria and who are found through administrative data to have received a particular service.
algorithm	A method used to create a calculated result. For example, algorithms are used to combine medical record results with administrative results to produce a measure's rate.
AMP repository	A database or file system that stores all the AMP information, including claims and membership and which may be updated during the data collection period.
anchor date	The date when the member must be enrolled with the PO. No gaps in enrollment may include this date.
audit result	Defines the suitability of measures for reporting. These results can be an approved rate of calculation or indication the measure is not reportable or biased *(BR).*
audit designation	Designations that are assigned by the HEDIS®[1] Compliance Auditor indicating the suitability of measures for public reporting.
bias (degree of bias)	Degree of error. AMP rate measures are reported using a 95 percent confidence interval.
carve out	An organization sponsor (e.g., employer, purchaser) contracts for a service or function (e.g., mental health, laboratory) to be performed by an entity other than the organization.
claim	A submission for reimbursement (e.g., from fee-for-service providers).
claims audit/ error rate	A rate that indicates the reliability of a claims processing system. Most POs review a sample of processed claims to compute an error rate, usually expressed as financial and nonfinancial.
claims dependent denominator	Determine the eligible population through claims data (e.g., diabetic members are identified by claims showing diagnoses for diabetes or dispensing of insulin).

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

claim or encounter processing vendor	Includes any external entity with which the organization has contracted to process claims or encounters.
comprehensive data	Complete records of patient care. Information about a member's every encounter with the health care system.
concurrent audit	Evaluation of methods and data during the data collection period. AMP Audit Reviews take place during data collection, allowing POs to correct errors before data are reported.
continuous enrollment	The minimum amount of time, including allowed gaps, that a member must be enrolled in the PO and/or health plan to be eligible for the measure.
corrective action	An activity the PO or plan completes between the onsite visit and data submission to correct problems that may result in a *Biased Rate (BR)*.
database	Data collected and organized in a computer file for ease of expansion, updating and retrieval.
data completeness	Determination or evaluation of missing data. Data-completeness issues must be quantified and *Biased Rate (BR)* designations must be supported by determination of material bias.
data completeness assessment	Assessment of the impact of claims lag, encounter data submission rates and studies on PO and/or health plan data completeness.
data consolidation	A combination of data from multiple sources, such as multiple electronic sources or electronic and medical record sources.
data extraction	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.
DMHC	Department of Managed Health Care. The licensing body for managed care in California that oversees all full and partial Knox Keene licensed health care organizations.
EDI	Electronic data 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. FAQs are posted to the NCQA website on the 15th of each month.
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.
health plan	An organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population.
HMO	Health maintenance organization. See **health plan**.
homegrown code	A diagnosis or procedure code not recognized nationally but used by the PO or health plan. Commonly found in mental health and preventive care.

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

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POS	Point of service. A HMO with an opt-out option that is accountable for financing and delivering a broad range of comprehensive health services to an enrolled population. Proof of service. Documentation from the legal health record that substantiates a service was rendered.
positive numerator event	Evidence of one measure-required service, event or diagnosis.
positive numerator hit	A member who satisfies the numerator requirements of a measure and who may be counted in the numerator. Some measures have multiple numerator requirements; for example, in the *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, Medicaid, Medicare.
provider	An institution or organization that provides medical services to patients. Examples of providers include hospitals and home health agencies. NCQA uses the term “practitioner” to refer to professionals who provide health care services; however, it recognizes that a provider directory generally includes both providers and practitioners, and that the inclusive definition is the more common usage.
reporting year	The year when AMP is reported and for which the volume is named. The year immediately following the measurement year.
required benefit	AMP measures evaluate performance and hold plans accountable for services provided in their members’ benefits package. Measure specifications include benefits or coverage categories (e.g., medical, pharmacy, mental health, chemical dependency) required during the continuous enrollment period.
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.
standard supplemental data	Electronically generated files that come from service providers (providers who rendered the service). Production of these files follow clear policies and procedures; standard file layouts remain stable from year to year.
supplemental data	Data other than claims and encounters used by the organization to collect information about the delivery of health services to members.
supplemental database	Automated data supplied by contracted practitioners, vendors or public agencies (e.g. immunization registries, schools or state public health agencies).

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

Appendix 4

Measures in the Scope of AMP Measure Certification

APPENDIX 4

MEASURES IN THE SCOPE OF AMP MEASURE CERTIFICATION

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

Encounter Rate for Clinical Measures

ENRST	Encounter Rate by Service Type

Clinical Measures

Cardiovascular Conditions

CBP	Controlling High Blood Pressure
SPC	Statin Therapy for Patients With Cardiovascular Disease
PDC	Proportion of Days Covered by Medications

Diabetes

CDC	Comprehensive Diabetes Care
SPD	Statin Therapy for Patients With Diabetes
SUPD	Statin Use in Persons With Diabetes

Musculoskeletal Conditions

ART	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
OMW	Osteoporosis Management in Women Who Had a Fracture

Prevention and Screening

WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents
WCV	Child and Adolescent Well-Care Visits
CIS	Childhood Immunization Status
IMA	Immunizations for Adolescents
CHL	Chlamydia Screening in Women
CCS	Cervical Cancer Screening
CCO	Cervical Cancer Overscreening
BCS	Breast Cancer Screening
COL	Colorectal Cancer Screening

Maternity

PPC	Prenatal and Postpartum Care

Respiratory

AMR	Asthma Medication Ratio
CWP	Appropriate Testing for Pharyngitis
AAB	Avoidance of Antibiotic Treatment for Bronchitis/Bronchiolitis

Appendix 5

Queries

APPENDIX 5
QUERIES

Onsite and Offsite Query Instructions

All auditors are required to conduct queries as part of every audit. Queries should be appropriate to the organization, to its data challenges and to its data and processes. Auditors must perform at least four queries but may perform more. The list below is not exhaustive and LOs or auditors may ask for custom queries. Save results from requested queries in the work papers for review during monitoring. When appropriate, run queries on the results (e.g., numerators, denominators) produced from the vendor's certified code or approved measure logic.

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

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

- ENP for all product lines.
- Membership and enrollment by month.
- Ensure that Exchange members are included in the commercial population.
- Duals (commercial/Medicare).
- Total Enrollment compared to ENRST compared to measure eligible populations. (AMP specific)
- Check AMP reports against external reports (e.g., finance department) for percentage of members with mental health/ pharmacy benefits:
  - Commercial PPO/EPO and Medicaid members.
  - Compare Medicare population against CMS enrollment files.
- Transactions by month (pharmacy, lab).
- De-duplication of pharmacy data loads to check for double counting.
- Missing primary diagnosis for inpatient visits.
- Missing rendering provider.
- Numerator hits in the source systems.
- Numerator misses in the source systems.
- Enrollment for members in the denominator.
- Diabetes diagnosis for CDC.
- Hypertension diagnosis for CBP.
- Members who did not qualify for a measure due to CE breaks.
- Frequency of codes loaded into software. For example, check the frequency of primary diagnosis codes to look for missing or incorrect values.
- Members who did not qualify for the EP. For example, run source code that identifies diabetics to look for diabetic members not included—no CE, only one claim.
- Immunizations before 1st birthday (Hep A).

- NPI completeness.
- Nonstandard coding review: Use a frequency of codes list from the organization to ensure that the mapped codes affect the appropriate and specific measures, and that they are counted as hits.