Audit Process:

Offsite Methods

The Offsite Audit Process

During an NCQA HEDIS Compliance Audit, many tasks are completed away from the organization’s location. The audit preparation phase includes all activities that occur before the onsite visit, such as contracting with the organization; negotiating a timeline; reviewing the Roadmap and the list of measures selected for reporting; and planning the onsite visit. Other offsite tasks are survey sample frame validation, source code review and MRR validation. The sections in this chapter follow the same order as a typical audit’s offsite activities:

* Contract Execution.
* Roadmap Assessment.
* Validation of Sample Frames for Survey Measures.
* Core Set Measure Selection for Source Code Review.
* Manual Source Code Review.
* Preliminary Rate Review.
* Medical Record Review Validation.
* Site Visit Planning and Conference Calls.

Contract Execution

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

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

NCQA lists Licensed Organizations on its Web site ([www.ncqa.org](http://www.ncqa.org)).

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| Selecting measures to report | The HEDIS Audit method incorporates all measures that can be reported to specific agencies or groups, such as CMS, state Medicaid programs or employer groups. As a part of executing a contract for a HEDIS Audit, the organization selects the measures to be reported. Because information systems are a foundation of measure reporting, a set of reported measures requires a comprehensive assessment of information system capabilities.  **Note:** The NCQA Health Plan Accreditation Program requires audited rates for all accreditation measures, including CAHPS Health Plan Survey 5.0H Adult Version results for the applicable product lines. |
| Negotiating a timeline and selecting systems | During the contracting phase, the organization and the Licensed Organization negotiate an audit timeline. To guide this negotiation, NCQA has set completion dates for several audit milestones.  **Note:** If milestones such as the Roadmap receipt date, the MRR stop date, or the submission tool submission deadline are missed, the organization might not have sufficient time to respond to the auditor’s requested corrective actions, and measures could be deemed Not Reportable (NR). Auditors should work carefully with key staff members, including organization executives, if milestone events are not met. |

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|  | The auditor and the organization review the number and configuration of the systems to be audited. Items to consider when contracting are whether multiple product lines or products rely on the same information system and whether several key organization functions are performed at multiple offsite locations. In all audits, the Certified Auditor uses findings from the Roadmap and information prior years’ audits, if applicable, to determine the systems to audit and the next steps in the audit process. |

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| HEDIS Audit Timeline Task | NCQA Deadline |
| Organization contracts with an NCQA Licensed Organization. | December 3 |
| Organization submits the completed Roadmap to the auditor. | January 15–31 |
| Auditor completes the survey sample frame validation. | January 31 |
| Auditor selects a core set of noncertified measures for code review. | February 15 |
| Auditor receives software vendor’s final certification report or organization submits completed source code for auditor review (for noncertified code). | March 1 |
| Onsite visits completed. | April 30 |
| Auditor selects measures for MRR validation and informs the plan of the selections. | May 1 |
| Preliminary rate review completed. | May 6 |
| Organization completes the medical record abstraction process for all measures and sends final numerator lists to the auditor for the measures selected and all exclusions for MRR validation. | May 15 |
| Auditor picks 16 records for each selected MRR validation measure and exclusions for review and informs the plan of the selections. | May 17 |
| Organization sends selected charts to the auditor for validation. | May 24 |
| Auditor begins communicating MRR validation results, which includes the MRR validation corrective actions, with the organization. | May 29 |
| Organization completes all corrective actions and follow-up requests; final rate review is completed to the plan-locked IDSS submission. | June 10 |
| Organization submits the auditor-locked commercial, Medicaid and Medicare IDSS submission with attestation to NCQA. *(****Note:*** *June 15 falls on a Saturday.)* | June 17 |
| Organization submits patient-level data for Medicare products only. | June 17 |
| Licensed Organization submits commercial, Medicaid and Medicare Final Audit Reports to NCQA. | July 15 |

Roadmap Assessment

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

NCQA requires the organization to give the auditor a completed Roadmap each year, with adequate responses to all questions. Roadmaps submitted subsequent to the initial year should indicate new or changed information, and the “Date of completion” section should be completed. It is the organization’s responsibility to provide the information; if it does not, the auditor must obtain clarification. The organization must submit a current signed copy of the attestation every year. An electronic version is acceptable.

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

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| Timing | The Roadmap must be completed so the auditor can plan onsite activities. The auditor uses the Roadmap responses to:   * Select the core set of measures, if applicable. * Identify areas that require further clarification.   The auditor must maintain the completed Roadmap and all supplements received during the audit as part of the working papers. |

Validation of Sample Frames for Survey Measures

A Certified Auditor must validate the HEDIS survey sample frame before the Certified Survey Vendor draws the final sample and administers the survey. Validation lets the organization correct errors and minimizes the possibility that the survey is administered to a biased sample, which would result in the measures and their components being assigned *NR.*

Eligible population criteria for survey measures, reporting options, guidelines for producing the Survey Sample Frame and criteria for assigning audit results are available in HEDIS 2013 *Volume 3: Specifications for Survey Measures* and the 2013 *November Update,* and are included in Appendix 7 of this volume.

Auditor Validation Process

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| ***Step 1*** | Verify that the organization contracts with an NCQA Certified HEDIS Survey Vendor to administer HEDIS surveys.  If the organization does not use a certified vendor, the measures and their components are *NR*. |
| ***Step 2*** | Establish a timeline for sample frame validation. The NCQA Certified HEDIS Survey Vendor gives the organization the date when it must receive the validated Survey Sample Frame, and the auditor must complete the validation by that date (generally, by the end of January). |
| ***Step 3*** | If the organization does not use NCQA Certified software, the auditor reviews the source code used to generate the survey sample frame and determines its compliance with specifications for survey measures. If there are problems with the source code, the auditor notifiesthe organization that corrective action is required.  Software certification validates that the eligible population criteria was applied correctly, including: age, gender, continuous enrollment, allowable gap, current enrollment, measure flags. It also validates that all eligible members were selected and the NCQA specified file layout is used.   * *If the survey sample frame method received a Pass status,* the auditor does not review the survey sample frame source code. * *If the survey sample frame method received a Pass With Qualifications status,* the auditor reviews the certification report to determine the reason. The auditor ascertains whether the organization performed the steps necessary to address the areas of qualification or, if not, whether there is material bias in the organization’s eligible population. * *If the survey sample frame method received a Fail status* and the organization uses an alternative method, the auditor evaluates the process used by the organization or vendor to produce the sample frame and verifies that the appropriate fields are included in the sample frame output file. |

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| ***Step 4*** | The auditor reviews the output file for every sample frame, verifying compliance with the required layout specified in *Volume 3: Specifications for Survey Measures*, and that the eligible population, or a correctly reduced sample frame that includes 30,000 members randomly selected from the entire Eligible Population, and all required data elements are included. For example, a *Flu Shots for Adults Ages 50–64* Eligibility Flag must be set for each member in the adult survey sample frame and the auditor must determine whether this flag is assigned correctly. For the *Children With Chronic Conditions* measure, a Prescreen Status Code must be included in the child survey sample frame and the auditor must assess whether this flag is assigned correctly.  Auditors must also analyze and assess the prevalence and completeness of membership data (e.g., full address [including zip code]; age outliers, gender ratios) for each survey sample frame.  There are no exclusions specified for HEDIS survey measures. Members excluded from the sample frame must be clearly documented and evaluated by the auditor during sample frame validation.  For survey measures, material bias is caused by a (+/–)10 percent difference between the eligible population and the survey sample frame. For example, if an error creating the sample frame results in more than 10 percent of the eligible population being excluded from the sample frame and the organization cannot correct the error, the sample frame is materially biased and the sample frame cannot be sent to the survey vendor. |
| ***Step 5*** | The auditor indicates approval of the sample frame in the Healthcare Organization Questionnaire (HOQ)*.*  The organization sends the sample frame and notice of the auditor’s approval to the Survey Vendor.  **Note:** The two components of step 5 do not have to occur in order. |
| ***Step 6*** | The organization’s process for managing medical and membership information is reviewed during the onsite visit. If findings from the onsite review indicate problems with the medical or membership systems, the auditor must notify the organization and the survey vendor that the survey results are at risk*.* |

*Note*

* *Medicare survey measures are collected, calculated and reported by CMS and are not in the scope of the HEDIS Compliance Audit. These measures include the Medicare CAHPS survey, the HOS, Advising Smokers to Quit (as a subset of Medical Assistance With Smoking and Tobacco Use Cessation), Flu Shots for Older Adults, Pneumococcal Vaccination Status for Older Adults), Management of Urinary Incontinence in Older Adults and Physical Activity in Older Adults.*
* *NCQA allows an audit result for a measure rendered by one auditor to be used in another auditor’s opinion without further review. If the organization’s survey is administered as part of a larger program (e.g., surveys performed by a state contract as part of an external quality review [EQR] program) and are not reported on a separate data submission tool, the organization may indicate on its submission tool the audit results from the state’s effort with another auditor. The organization’s work papers should include the appropriate documents from the auditor rendering the final result.*

Core Set Measure Selection for Source Code Review

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

If the organization uses NCQA Certified software, the auditor does not select a core set of measures. The auditor must review all measures not included in the certification program and any measures that failed certification that the organization intends to report. Measures not included in certification that do not have source code should be reviewed for proper reporting processes. Refer to Appendix 9 for a list of measures not included in software certification.

The auditor evaluates the information in the Roadmap, the organization’s previous measure results and standard programming features to select a set of measures that represent the organization’s unique system for measure reporting. Selecting the core set is the sole responsibility of the auditor; the organization may not assist in the selection. The organization supplies the source code and the auditor investigates it for compliance and its impact on measure results. The measures selected for the core set may contain characteristics or programming features common to a group of measures:

* Complex continuous enrollment criteria.
* Identifying live births.
* Complex code mapping handled in software.
* Sampling logic.
* Identifying exclusions.

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

Rationales for Core Set Selection

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

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| Data issues | * The organization receives and incorporates vendor data. * The Roadmap indicates possible incomplete data. * Code mapping should be reviewed. * The organization implemented a system conversion. * The rate or denominator is an outlier. * Varied organization demographics should be reviewed. * Data integration should be reviewed. * Changes to report production should be reviewed. * The core set expanded to include state and federal agency measures. * Incentives are offered for measure rate performance. |

Additional Core Set Considerations

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| HEDIS core set composition | The HEDIS core set must have a minimum of 15 HEDIS measures from any domain, plus the CAHPS adult and children surveys, when applicable. If the organization reports fewer than 15 measures, the auditor must review the source code for all HEDIS measures.  Because of the rigorous review required for the HEDIS CAHPS surveys, all sample frames and source code (if applicable) are reviewed in addition to the base 15 HEDIS measures.  The Certified Auditor should work with the organization on the core set schedule, reviewing the HEDIS hybrid measures early and the HEDIS administrative measures later (but in time to catch problems calculating rates). |
| DM core set composition | The DM core set must include all DM measures for organizations audited only for DM reporting, not in conjunction with any other HEDIS Compliance audits. |
| WHP core set composition | The WHP core set must include all WHP measures for organizations audited only for WHP reporting, not in conjunction with any other HEDIS Compliance audits. |
| Combining core sets | If the organization is audited for DM reporting in addition to HEDIS, the core set should be expanded based on the following scenarios.   * *Plans that internally program HEDIS and DM measures* should expand the core set to include at least 2 DM measures in addition to the base 15 HEDIS measures. The auditor should review any DM specific indicator (e.g., the smoking cessation indicator) and any other area where HEDIS and DM differ. * *Plans that internally program only DM measures and use a certified software vendor for HEDIS* should expand the core set to include all DM measures.   If the organization is audited for WHP reporting and for HEDIS, the core set should be expanded to include all WHP measures in addition to the base 15 measures. Because there are few similarities between WHP and HEDIS measures, source code should be reviewed for all WHP measures.  The core set expansion is appropriate only if the same programmers are used for both HEDIS and DM. If different programmers are used, the entire measure set must be selected for review. |

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| Measure rotation | Rotated measures are not included in the core set. For these measures, the Certified Auditor validates only the audit results and rates from the previous year.  If the organization changed the measure rotation following the core set selection, the auditor must expand the core set to include the minimum 15 measures. |
| Core set expansion | The auditor bases the section of core set measures on the organization’s software processes and Roadmap responses, but it may be necessary to revise the core set during the onsite visit, when measures that require detailed assessment of organization processes are identified more readily. The auditor may review additional measures to ensure that findings for related measures are consistent, based on findings during the onsite visit. For example, if the auditor discovers a problem with identifying live births, the impact of the problem must be assessed for all measures that require live birth data.  **Note:** The core set may be revised or expanded at any time during the audit. |
| ASCR and multiple core sets | If ASCR was performed by another Licensed Organization, the auditor should consider the following items when selecting a core set.   * The core set should not be based on the ASCR list from the facilitating Licensed Organization, but the auditor may eliminate measures certified by NCQA for the organization. * The core set should include all measures not in the scope of certification (e.g., *Call Answer Timeliness* and *Board Certification*). * The auditor should review the source code for measures that are on the ASCR list but were not certified by the March 1 deadline. |

Manual Source Code Review

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

If the organization uses NCQA Certified software or ASCR and the measure has a *Pass* status, the audit team reviews source code only for algorithmic calculations.

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| Source code process | To ensure that the reviewer can perform a thorough assessment of source code,  the organization must provide flowcharts; software documents that explain the programming logic and design; input and output file layouts and field descriptions; input and output counts; and run logs.  The source code review process can be completed in one of two ways.   1. The Certified Auditor analyzes the code independently before or after the onsite review and communicates perceived discrepancies to organization staff.  * *Saves time, but may result in more questions if the reviewer does not fully understand the organization’s system.*  1. The auditor examines source code with organization staff during the onsite visit.  * *May be more efficient if it can be completed during the onsite visit.* |

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|  | An advantage to code review is that it lets the reviewer quickly and easily determine whether certain tests have not been performed. It may be difficult to verify that the code properly checks for continuous enrollment, but it is easy to ascertain if the code tests the proper age range or performs a required gender test. Similarly, exclusions based on clinical codes can be readily determined.  A common challenge of code review is that viewing a program sequence does not ensure that the code was executed properly. The examined code may have been bypassed partially or completely. The auditor must check to make sure that the program ran as specified. One way to do this is to rerun the code against the original files, which requires a file freeze of the measure repository. Another method of testing the code is to run it against a test file prepared by the auditor in the format of the expected input file. If the subset is small, the auditor can select a subset of the total file (pre-denominator extract) and hand-check the results.  An alternative is to prepare a set of data (a **test deck**) with known results, modify the organization’s program to read it and compare program results with expected results. |
| HEDIS determination | For each measure in the core set, the auditor documents that the source code meets the HD standards. If the core set measures are expanded, the auditor also documents the additional measures. |
| Review results | The source code review can have one of three results:   1. Agreement that the code produces the intended and appropriate output. 2. Questions about aspects of the code that require programmer review and possible job reruns. 3. Determination that the code is inadequate and must be rewritten before the results can be accepted. |
| ASCR or certified software | An organization that uses certified software or completed ASCR is exempt from manual source code review for all passing measures; however, the auditor must still evaluate:   * Organization-to-vendor field mapping. * Organization-specific mapping (e.g., mapping of proprietary codes). * Data scrubbing or cleaning routines conducted before measure calculations (by either the organization or the vendor). * Organization-specific data integrity and medical coding issues, especially concerns that could affect the accuracy of the reported rates. * Application of customized measure logic that is by nature idiosyncratic (e.g., organization-specific methods for identifying live births for OB-related measures). * MRR tools and logic, including data entry screens, database layout and the combination of medical record and administrative data (confirm that the software applied the 14-day rule). * Algorithmic calculations. * Vendor compliance with IS standards, especially concerns that could affect the accuracy of reported rates. * IDSS import tools.   The auditor may use any method discussed to evaluate these areas, including running queries. The auditor should document the methods used and the results, and determine if measures were run with certified source code by comparing the date and version of output with the date on which the measure received a *Pass* status and the date and version of source code release from the final Software Certification Report. |

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| Certified software | The certification program certifies the software vendor code, but not organization-specific implementation of the code. Confirmation that the organization used the NCQA Certified version of the software is the responsibility of the Certified Auditor. If the organization uses NCQA Certified software, the auditor must compare the software version number with the vendor’s Certification Report.  The auditor must evaluate measures with a *Pass With Qualification* status. Measures receive a *Pass With Qualification* status when the vendor’s output file does not match NCQA’s file but the results are unlikely to cause material bias at the program level. This documented decision should include a description of the code insufficiency and the auditor’s validation methods to determine the impact for the particular organization.  Measures with a *Fail* status should result in *NR* unless the health plan or vendor produced the rate accurately by some other method. The auditor must review the steps taken to ensure that reported rates meet specifications and are not materially biased. This documented decision should include a description of the organization’s resolution for the code insufficiency and the auditor’s validation methods. |

Preliminary Rate Review

**Preliminary rate review** provides the Certified Auditor with initial administrative and hybrid rate information. The auditor uses the initial rate review to assess data completeness and accuracy early in the audit. Significant rate variations found during preliminary rate review are recorded, discussed and corrected if needed.

Medical Record Review Validation

**Medical record review (MRR) validation** is an important component of the audit. It tests that medical record reviews performed by the organization or its contracted vendor meet audit standards for sound processes and that abstracted medical data are accurate. If the MRR process—which includes training, tools, interrater reliability checks, rater-to-standard tests or any other quality control process—is different by plan, product or product line, the auditor must conduct separate MRR validations for each process. Medical records abstracted at a practitioner’s office are subject to the same audit policies as records abstracted by the plan or by a vendor.

**Note:** MRR validation is not affected by the use of certified software. Although NCQA certifies the production of the systematic sample, the steps below and the combining of medical record data and administrative data are not included in software certification.

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| Organization responsibility | An organization that chooses to use the Hybrid Method for a measure should attempt to pursue charts for all noncompliant members in the systematic sample to preserve the integrity of the sample and its representative rate.  After the systematic sample is generated and chart pursuit has started, the sample  may be reduced on rare occasions, such as after a natural disaster. Removing uninvestigated members from the sample in this situation is an alternate sampling method, and the organization should submit a request for approval to PCS at [www.ncqa.org/pcs](http://www.ncqa.org/pcs). The request should include the reason for not completing chart review, and the auditor’s approval showing that the members to be removed are systematically distributed across the larger sample and the hybrid results from the reduced sample are reportable. |

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| MRR evaluation | Early in the organization’s MRR process, the auditor reviews operational components to ensure the following:   * The systematic sample was created correctly or passed the Software Certification process. * MRR training sessions are complete and consistent. * MRR forms or tools and instruction materials collect information according to the specifications. * Rater-to-standard or interrater reliability quality control testing protocols, standards and reports are statistically sound. * If applicable, practitioners had correct medical record abstraction tools and instructions and medical records reviewed by practitioners meet audit standards and were subject to quality control testing. * MRR data entry or uploading processes for adding MRR data to the repository is correct. * Data entry and data transfer processes for combining medical record data with administrative data to calculate the final rate are accurate. This step may require source code review of the MRR vendor’s tools or processes. |
| Convenience sample exemption | The auditor reviews a convenience sample to find errors in the MRR process early enough for the organization to take corrective action. Unless determined exempt by the auditor, the organization must prepare a convenience sample. To be considered exempt, these criteria must be met:   * The organization participated in a HEDIS audit in the prior year and passed the MRR validation portion. * The organization’s current MRR process has not changed significantly from the prior year (e.g., MRR team qualifications, training, documentation, abstraction forms and quality control processes are similar). * The organization does not report hybrid measures that the auditor determines to be at risk of inaccurate reporting.   Even with an exemption, the organization may request a convenience sample review and should work with the auditor to determine the timing. If the convenience sample is required, the plan may not select the measures or the charts to review. If the sample is not required, the plan may select specific charts for the auditor to verify. The prior year’s audit opinion from another audit firm does meet the criteria for exemption.  The auditor must document the organization’s exemption or its convenience sample process, including the measures that were reviewed and why they were selected. |
| Convenience sample validation | Early in the organization’s MRR process, the auditor reviews a small number of processed medical records to uncover potential problems that may require corrective action. The auditor selects up to 10 hybrid measures that may be difficult to review because of complex logic or system problems. For these measures, the auditor gets copies of at least two completed MRR tools and medical charts that qualify as positive numerator events or exclusions.  The auditor may request copies of negative events, exclusions or additional positive records based on findings from the Roadmap or other process reviews. The auditor compares the completed tools with the medical records to determine if the organization correctly identified the numerator or exclusion events. The organization can correct any systemic problems in its MRR process before proceeding with additional reviews. |

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| Final statistical validation | The final statistical validation is a more extensive review of medical records and occurs after the organization’s abstraction process. It ensures that the organization’s MRR process was executed as planned and that the results are accurate. The final statistical validation must take place on or before June 10, 2013, giving the organization time to implement any corrective actions and giving the auditor time to validate the corrections.  The results from the final statistical validation may influence the audit results for hybrid measures reported by the organization.  **Note:** The organization should keep the original or a copy of each medical record given to the auditor for the convenience sample and the final statistical sample. |
| *Step 1* | The auditor selects one measure from each measure group that applies to the health plan and to all exclusions for the exclusions group (see Table 1). Selections are based on criteria such as new or revised measures, complex measures or low rates in previous years.  ***Note:*** *If the plan does not report any measure in a particular group, auditors will use their discretion, based on past performance and current progress, to determine if an additional measure should be selected from another group.* |
| *Step 2* | The health plan sends the auditor a list of all numerator-positive members for each selected measure, and all hybrid exclusions for all measures by May 15. If the plan completes the medical record process early, the plan may submit all measures for validation before May 15 with the understanding that no additional medical records hits will be accepted.  **Note:** Auditors must also receive a final numerator count for every hybrid measure. These counts are randomly compared to counts entered in IDSS. Any changes in the final counts must be explained by the plan. |
| *Step 3* | The auditor randomly picks 16 records from each numerator-positive-member list for each selected measure and from the exclusions group. The plan is informed of the selections and must send the charts for review. If there are fewer than 16 numerator-positive charts for the measure, the auditor reviews all charts or selects another measure. If a record is not available for the auditor’s review, it is considered an error.  **Note:** The auditor may make selections from Group F based on groupings by measure or type. |
| *Step 4* | The auditor reviews the records for adherence to the HEDIS specifications, and rejects the charts that do not pass review.  The auditor looks for critical errors that change the member’s numerator compliance (e.g., a numerator positive to a numerator negative). At the auditor’s discretion, noncritical errors may be allowed, such as a misidentified date that does not change numerator compliance for the member. |
| *Step 5* | If no charts fail, the measure and the measure group pass the process. If errors are detected, the following rules apply.  Measures with one error do not pass the validation process, and the corresponding measure group is considered at risk for Not Reportable (*NR*) audit results. The auditor is required to document the investigation of the error type and whether it could affect other measures in the group.  If only one error is found in the original MRR validation sample, the auditor may retest using a second 16-record sample that does not include the original sampled records.  If the second sample is free of errors, the measure and measure group pass. |

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|  | If there are one or more errors in the second sample, the measure and measure group do not pass and cannot be reported until all errors are corrected and reviewed by the auditor.  If two or more errors are found in the original sample, the auditor does not perform additional testing because the likelihood of the second sample failing is high. The measure and measure group do not pass until the plan corrects all errors and the auditor approves the charts.  **Note:** The auditor may decide what follow-up items are required for correcting the errors. Follow-up requests may include reviewing policies and procedures for fixing the errors, a full review or a sample of re-abstracted charts, updated numerator counts, and a final hybrid rate review.  If there is not enough time to correct errors, the plan may not report the measure using the Hybrid Method. A plan with uncorrected MRR validation errors may report using only the administrative rate for the measure and the measure group, or an NR audit result must be reported.  **Note:** For any product line, if a hybrid measure is required to be reported and the audit result is NR, the auditor must select only one of two comments in IDSS: “the measure was materially biased” or “the plan chose not to report.” The plan may not unselect a required measure. |
| *Step 6* | Testing the exclusion group follows the same process as testing measures, except that the auditor reviews a sample of 16 records of all hybrid measure exclusions. Exclusion errors affect the measure for which the exclusion was applied (and possibly affect other, similar measures), and their use is subject to the auditor’s review.  **Note:** After the MRR validation process is complete the auditor may request additional corrective actions, based on subsequent audit findings, or may ask to review more measures. |

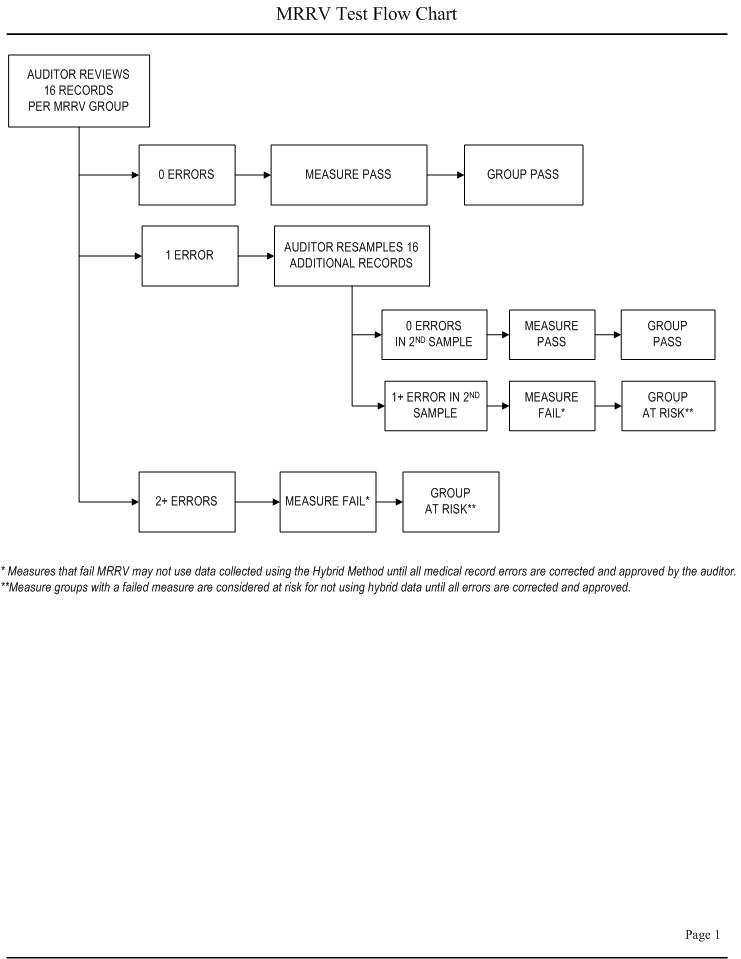
### Table 1: MRR Validation Measure Groups

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| Group A: Biometrics (BMI, BP) and Maternity | Group B: Anticipatory Guidance  and Counseling | Group C: Laboratory |
| * Adult BMI Assessment (ABA) * Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI * Comprehensive Diabetes Care (CDC)— BP <140/80 * Controlling High Blood Pressure (CBP) * Prenatal and Postpartum Care (PPC)—Prenatal * PPC—Postpartum * Frequency of Ongoing Prenatal Care (FPC) | * Well-Child Visits in the First 15 Months of Life (W15) * Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) * Adolescent Well-Care Visits (AWC) * WCC—Nutrition * WCC—Physical Activity | * CDC—HbA1c Rates * CDC—LDL <100 * CDC—Nephropathy * Cervical Cancer Screening (CCS) * Cholesterol Management for Patients With Cardiovascular Conditions (CMC)—LDL-C <100 * Lead Screening in Children (LSC) |
| Group D: Immunizations and Other Screenings | Group E: SNP | Group F: Exclusions |
| * Childhood Immunization Status (CIS)\*\* * Immunizations for Adolescents (IMA)\*\* * Human Papillomavirus Vaccine for Female Adolescents (HPV) * Colorectal Cancer Screening (COL) * CDC—Eye Exam | * Care for Older Adults (COA)—Advance Care Planning * COA—Functional Status Assessment * COA—Medication Review * COA—Pain Screening * Medication Reconciliation Post-Discharge (MRP) | * All medical record exclusions\* |

*\* Group F includes all optional and required exclusions found during medical record review, and valid data errors. It does not include records excluded through administrative data or that belong to employees or their dependents. Other hybrid medical record exclusions that should not be reviewed in Group F are exclusions for the CDC—HbA1C <7 indicator. Because of the large volume, auditors review exclusion rates for this indicator separately.*

*\*\* Selecting a combination rate for these measures is preferred, but a single antigen may be selected at the auditor’s discretion.*

### Sampling Flow Diagram



*Note*

\* Measures that fail the validation may not use data collected using the Hybrid Method until all medical record errors are corrected and approved by the auditor.

\*\* Measure groups with a failed measure are considered at risk for not using hybrid data until all errors are corrected and approved.

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| Extrapolating to other measures | The results of the final statistical validation can be extrapolated to other, similar measures, regardless of the MRR validation groups, when similarities exist based on logical groups, required data elements, medical record review staff and types of abstraction errors. As with the core-set expansion option, however, when significant problems are found during the validation, the auditor must determine if similar measures should be reviewed. Expanded validation measures are treated to the same scrutiny and statistical evaluation as the original measures. |

Measures With Special Considerations

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| *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* | This numerator is unique in that the calculated rate measures poor performance. Consequently, auditors must pull a sample of up to 16 medical records that *do not* meet numerator criteria (i.e., selected from Box B in the table below). |

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| Box A: Meet Numerator Criteria | **Box B:** *Do Not* **Meet Numerator Criteria** |
| * No HbA1c test, ***or*** * No HbA1c lab value, ***or*** * HbA1c lab value is equal or greater than 9.0%   ***Note:*** *If any criterion is met, the member is included in the numerator criteria.* | * Had HbA1c test, ***and*** * Had HbA1c lab value, ***and*** * HbA1c lab value is equal or less than 9.0%   ***Note:*** *All 3 criteria must be met for the member to be considered not meeting numerator criteria.* |

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| *Controlling High Blood Pressure* denominator | Medical record review of this measure requires confirmation of the denominator and the numerator. If an unusual number of false-positive exclusions are reported by the organization, the auditor should review the accuracy of the reported denominator by a random sample of 16 records from the denominator (i.e., confirmed hypertension medical records) and confirming the accuracy of the sample. The auditor should document the findings. |

Supplemental Data Validation

**Supplemental data validation** is an important component of the audit. It tests that supplemental data collected or received by the organization meet audit standards for sound processes and that data are accurate. All supplemental electronic data are subject to audit review and differ only in the degree of review required. For each source of supplemental data, the auditor must conduct separate validations, which includes reviewing policies and procedures, data file formats and any quality control processes. Primary source validation may also be required.

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| Audit requirements | All supplemental electronic data are subject to audit review and differ only in the degree of review required. |
| ***…for standard files*** | The auditor is not required to conduct primary source verification to check the accuracy and validity of data obtained from standard files such as laboratory data, but must request documentation to ensure that the agency or organization responsible for the data has reasonable processes in place for data collection and accuracy. |
| ***…for non-standard files*** | For internal or external nonstandard files, the auditor must perform primary source verification every year that the database is changed and the previous verification is not applicable. If the auditor does not perform primary source verification, the work papers should include a database-specific explanation. Primary source verification involves the following tasks:   * Create a randomly selected sample using acceptable methods (e.g., the sample feature in Excel). After evaluating the measures and databases, the auditor is responsible for selecting the appropriate number of records for primary source verification. * Review the original paper record or the electronic record (e.g., EMR screen) for each member in the sample. |

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|  | The auditor must also consider variable factors when deciding how many records to review.   * *Timing of access:* The audit review may occur before or after the database is used to help calculate measures. The auditor must assess the effect of the measures based on the timing of the review. * *Timing relevance:* A supplemental database may be created and augmented across multiple years. The auditor must assess and review use of records pertaining only to the year being measured. * *Use for multiple measures:* The auditor must base determination of the primary source validation on the number of measures affected and the number of records affecting each measure.   The database may not be used if the auditor does not have access to the primary source. Because of the variety of files, sources and results, the auditor must assess the processes and their impact, perform primary source verification and determine the validity of the database for use in calculating the selected measures. |
| ***…for all files*** | The auditor evaluates the policies and procedures for collecting and managing, mapping, importing and reporting the data. The organization provides the auditor with the following documentation, and the auditor keeps a record of the details, for each supplemental database:   * The method used to create supplemental database. * Quality assurance or oversight used. * Data quality controls in place. * Data security in place. * Ongoing maintenance. * The method used to transmit the supplemental data file. |

*Note*

* *Data-request forms may not be sent for noncompliant members in the systematic sample for hybrid measures. All reviews for members in the sample must follow the hybrid measure chart review specifications described in Volume 2, General Guideline 40: Obtaining Information for the Systematic Sample.*
* *Organizations should not create records or an ongoing database of exclusions for clinical conditions that might change.*
* *Data pulled from medical records for chart review for a hybrid measure may be added to a database and used in subsequent HEDIS reporting years, but the elements must comply with the guidelines for data element requirements and audit review.*

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| Database bias assessment | If the auditor determines that the supplemental data source is biased, the organization may not use these data for reporting. Bias determination is based on the degree of data completeness as determined by the auditor’s review of the primary source documents. |

*Note*

* *Medical records collected as a part of supplemental data validation may be destroyed after the monitoring visit.*

Planning the Onsite Visit

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| The onsite audit team | After an initial Roadmap review and core-set selection, the auditor forms the onsite audit team. Two team members are recommended for the onsite visit—one of whom must be a Certified HEDIS Compliance Auditor (CHCA). The Certified Auditor bases team members selection on the unique characteristics of the entity being audited. Auditors on the team should have a mix of skills: | |
| * Measure knowledge. * Data modeling skills. * Claims experience. * Enrollment experience. * Practitioner information experience. * Information systems experience. | * Programming experience. * Interviewing skills. * Merger or acquisitions knowledge. * Data warehousing experience. * Medical record review experience. |
| The lead auditor may base team structure on the number and types of locations that require onsite visits. Depending on the size and type of system to be reviewed during the visit, NCQA requires enough individuals for complete interviews and thorough system review and documentation, with the Certified Auditor serving as the team leader. At least one Certified Auditor is required per organization site visited. | |
| Team structure examples | *The audit of a single-site organization* may require a single team with a lead Certified Auditor and one or two assistant auditors for evaluating organization systems and processes. This audit may also be structured to have two Certified Auditors, with one or two assistant auditors simultaneously working in two teams (one addressing IS compliance and another evaluating HD compliance).  *The audit of a multi-site organization* may base team selection on the specialized nature of each site; therefore, the credentialing center audit team would differ from the audit team used to evaluate behavioral health or non-certified source code vendors. | |
| Audit kick-off discussions | After the audit team is organized, the lead auditor meets with the organization (in person, by phone or through Web presentation) to select the relevant onsite visit locations, identify offsite issues and make offsite requests, such as source code and supporting documentation for the core set measures or noncertified measures. About two weeks before the onsite visit, the team contacts the organization to review the onsite agenda, resolve issues and ensure availability of requested documentation and staff.  For a single-location organization, NCQA recommends that the onsite visit last from one to four days. If the audit team will visit multiple locations, additional days may be necessary to evaluate information needed to complete the onsite visit. The audit team should develop an agenda that satisfies these requirements, addresses audit risk areas and accommodates the organization. | |

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| Sample Onsite Agenda | |
| **Day One** | |
| ***Both Process and Measure-Specific Teams*** | |
| 1. Introductions.  2. Overview of the organization.  3. Explanation of the audit process.  4. Overview of claims or encounter data system and processes.  5. Overview of enrollment or membership data system and processes.  6. Overview of practitioner data system and processes.  7. Overview of vendor data systems and processes.  8. Data warehousing.  9. Overview of information systems or decision support system.  10. Overview of processes for collecting measures.  11. Overview of medical record abstraction process and convenience sample.  12. Initial review of organization data systems.  13. Provision of supplemental documentation.  14. Preliminary rate discussion or review.  15. Team discussion of findings and outstanding data request. | |
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| **Day Two** | |
| ***Process Team*** | ***Measure-Specific Team*** |
| 1. Detailed review of claims or encounter data systems and processes:   * Forms and coding. * Data entry (paper and electronic). * Claims and encounter data flow.   2. Detailed review of enrollment or membership data systems and processes.  3. Detailed review of practitioner data systems and processes.  4. Detailed review of data warehousing. | 1. Detailed review of measure-specific data collection:   * Review source code issues and output files with measure programmer. * Run queries to assess results. * Assess MRR process, abstraction forms and findings. * Interview data collection staff. * Document findings. |

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| Sample Onsite Agenda | |
| **Day Two** | |
| ***Process Team*** | |
| Detailed review of information systems or decision support systems:   * Creating data repository. * Incorporating ancillary and vendor data. * Data control or security procedures. | |
| ***Both Process and Measure-Specific Teams*** | |
| Joint team discussion of findings and outstanding data requests. | |
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| **Day Three** | |
| ***Process Team*** | ***Measure-Specific Team*** |
| Detailed review of practitioner measure data collection. | Detailed review of measure-specific data collection. |
| ***Both Process and Measure-Specific Teams*** | |
| 1. Audit team discussion of findings and measures at risk.   * Verify that all documents necessary to support findings are included for each measure. * Verify that all proprietary information is returned to organization.   2. Closing session with organization.   * Present initial audit findings. * Potential *NR* measures resulting from preliminary rate review findings. * Discuss items for corrective action and follow-up, including target dates for completion. | |

Audit Process:

Onsite Methods

The Onsite Audit Process

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| Site visit | The onsite visit, a required part of the audit process, allows the auditor to investigate issues identified in the Roadmap and observe systems used to collect and produce measure data. An onsite visit can take up to four days and is conducted by an audit team. At least one Certified Auditor must be present to lead the onsite visit; other team members do not need to be Certified Auditors. The auditor is required to keep a dated attendance sign-in sheet from the onsite visit.  The audit team interviews organization staff members; reviews organization information system structure, protocols and processes; and reviews organization measure-specific data collection processes with the organization staff responsible for selected measures. The team concludes the onsite visit with a closing session, during which it shares initial findings and additional documents or corrective actions needed.  Additional onsite visits may be required for an organization with delegated vendors or offsite facilities relevant to measure production. For large national organizations, onsite visits may take place at local offices, regional processing centers or corporate headquarters. The number and structure of onsite visits depend on the size and structure of the reporting organization. |
| Opening meeting | The opening meeting introduces the audit team to the organization staff in charge of measure development and reporting and gives the organization an opportunity to present an overview of the entire data collection process.  The members of the audit team explain how they conduct an NCQA HEDIS Compliance 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 NCQA Certified HEDIS Compliance Auditors either receive or request additional information. |

Onsite Audit Methods

The Certified Auditor assesses the ability of the organization’s systems and processes to produce reliable HEDIS or performance measure results and the extent to which the organization staff has accurately interpreted the specifications. The auditor uses several tools and techniques, including interviewing, primary source verification, process review, system or program review, observation, data file content review and source code review.

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| Interviewing | Throughout the onsite visit, the audit team interviews organization staff to gain insight into the accuracy and reliability of the reported measure results. Members of the audit team may also accompany a staff member to another site where information is processed, or communicate via conference call with the staff located off site.  On site, the auditor verifies responses in the Roadmap and obtains more detail by interviewing staff members who are familiar with the organization’s information systems and involved in the measure data collection process. The auditor records the name and title of everyone interviewed. |

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| Discussion Topics and Recommended Organization Personnel to Be Interviewed | |
| HEDIS or performance measure team leader | * Overall data collection and reporting * Preliminary rate reviewand rationales |
| Quality improvement director | * Use of measure information * Underlying data issues |
| Medical record review supervisor | * MRR process, training, abstraction tools, audit procedures and results |
| Operations management director | * Claims or encounter processing, member services or call center management |
| Credentialing department supervisor | * Credentialing system used for maintaining practitioner data |
| Information systems (services) | * All systems and databases supporting reporting |
| Finance personnel | * Use of financial records for relative resource use measures |

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| Interview questions | Interviews are tailored to the organization’s data production environment and issues raised by the 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 the clinical data captured and what formats are used for the delivery vehicle? * How are data delivered to the organization and what are the proportions by delivery type (electronic, mail, courier, fax)? * How are data manipulated to produce the data 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 Roadmap. The auditor examines all paper forms and other input media (e.g., claims or encounters, practitioner credentialing documents, EDI protocols) used to collect data.  The review verifies that the information from the primary source matches the output information used for reporting. The review addresses content and format and traces the movement of data from the originating source to the data 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 Roadmap may state that all practitioner claims contain certain data (e.g., codes and dates) and the practitioner manual may state that the data are 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. |

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| Forms and data  to review | Examples of forms data (including electronic submissions or EDI) that typically contain measure-relevant data and should be reviewed are: | |
| * Practitioner claims and capitated practitioner encounters. * Hospital claims and encounters. * Prescription data. * Lab result forms or files. * Survey forms. * Employer-initiated enrollment data. | * Member-initiated enrollment data. * Practitioner demographic forms. * Practitioner credentialing forms. * Claims logs. * Call system reports (volume, time to answer). * Supplemental data forms. |
| Process review | The organization should have documentation describing the processes that apply to each IS standard: collecting, storing and reporting data. The auditor reviews the documents and explores the organization’s methods to ensure that policies and procedures are followed, focusing on the integrity and completeness of the data required. Documentation describing incentives to perform procedures properly is critical.  Documentation processes and forms might not change from year to year. For initial audits, or in years where there were system or process changes, NCQA requires the auditor to review all applicable documentation. For subsequent audits, the auditor may exercise discretion when systems and processes have not changed. The auditor may observe certain procedures during the onsite visit. Examples of documents that might be examined include:   * Instructions and forms for submitting member-level information regarding enrollment additions, deletions and changes. * Documents should specify data required to open and update records, and problems resulting from noncompliance. * Instructions and procedures for collecting and entering credentialing and other practitioner-level data. * Instructions and procedures should specify the data required to properly open and update records, and problems resulting from noncompliance. * Training and procedure manuals for claims and encounter, membership and practitioner data entry staff. * Documentation should describe objectives, methods and processes; how performance is monitored and measured; 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. | |

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| 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 organization supplies documents describing how particular computer systems or computerized files operate. Computer processes can be described by text, code and flow charts. Electronic files can be described by text, file layouts and data dictionaries.  Because NCQA requires auditors to review relevant systems and processes during an onsite visit, the auditor must review and understand data and systems-oriented documents, for example:   * Record file formats and descriptions for entry, intermediate and repository files that contain the information necessary for the auditor to perform a file scan and understand the results of the scan. * Documentation for data receipt, entry, transfer and manipulation, showing how programs interact with the operations, if documentation is explicit about user options and program paths. * Flow charts describing data flow and the systems involved, including review of automated call systems. * Descriptive documents of third-party code; date of receipt, including procedure, diagnosis, revenue 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 records all organization 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. The observation may assess data entry or other data manipulation:   * Data entry of membership updates, claims or encounters and practitioner data. The auditor should confirm 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 to confirm that prescribed procedures are followed.   During the observation process, the auditor follows a systems operator through receipt and entry or processing of several types of source data and documents how well the operator adheres to procedural guidelines. |

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|  | 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 the data are processed inaccurately or incompletely. While observing the claims process, the auditor may ask the claims processor to perform the following tasks:   * Enter an incomplete member number. * Process the claim without a provider ID. * Enter an inconsistent member diagnosis combination (e.g., male and hysterectomy).   NCQA requires the audit team to observe onsite the systems and processes necessary to ensure compliance with IS and HD standards. At a minimum, the audit team must ensure onsite that all systems and processes used to produce measure data are verified and understood. |
| Data file content review | The auditor also examines data files, and may review and validate a number of file types to verify that data are stored and processed properly and can be manipulated to produce accurate results. Files that might be examined include:   * Transaction files created to contain clinical events, membership and practitioner changes. * Intermediate files created by extracts, queries and analysis applications. * Data repository files (i.e., input to measure computation programs). * Denominator files for measures.\* * Sample files randomly selected from denominator files.\* * Numerator files based on administrative data and the medical record review process.\*   \*This step is not necessary for measures where the organization uses NCQA-Certified software or ASCR.  The first three file types are related to the IS standards because they are associated with preserving the integrity of the data in the repository; the last three pertain to the HD standards. The auditor confirms the integrity of files for all categories. Review methods depend on file type; potential for corruption; complexity of programs that build and update files; and file access capability. By examining file layouts, the auditor determines if certain fields are missing, such as:   * Multiple practitioner locations. * Multiple practitioner specialties. * Number of prior membership segments. * Prior membership ID. |

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| File content examination methods | * Request transaction file output and compare to a sample set of source documents (e.g., 20 or 30 records). The auditor compares the data entry result to the entry documents’ content and checks 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 with 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. Since 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., enrollment and 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 organization classifications. * Verify codes used to identify members who meet the measure criteria (denominator or numerator). * Verify adherence to small eligible population guidelines. |

Data Completeness Findings and Impact Determination

Before the onsite visit, the Certified Auditor must review the Roadmap and identify possible areas of concern. During the onsite component of the audit, the auditor should assess the organization’s claims lag and encounter data submission rates, along with studies on data completeness that the organization may have performed. Data completeness issues must be quantified, and any *NR* must be supported by a determination of material bias.

NCQA provides the auditor with audit means and percentiles by product line for nearly all performance measures. The auditor uses the means and percentiles to conduct reasonability assessments of the initial and final measure results calculated by the organization. An *NR* should not be assigned to a measure whose rate is either well below or well above the mean rate without further investigation of data completeness concerns for the reporting method used.

For assessment of data completeness, NCQA provides the auditor with enrollment ratios of eligible members to product line. As with the means and percentiles, an *NR* should not be assigned to a measure whose enrollment ratio is significantly above or below the mean enrollment ratio. Further investigation must be conducted to determine if data completeness issues affect the measure rate.

Closing Conference and Follow-Up Documentation

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

During or after the onsite visit, the auditor prepares *written* confirmation of the initial findings conveyed in the closing conference, giving the organization reasonable time to review and respond. The documents contain these important items:

* A list of unresolved questions and deficiencies found in the Roadmap, during the visit or during preliminary rate review, with corrective actions and their completion dates.
* A list of additional documents needed to complete the Roadmap or the onsite visit, with submission dates.
* The auditor’s conclusions and preliminary assessments, with supporting evidence.
* The impact that these items have on data collection and reporting, specifically indicating the measures at risk.
* A timeline for finalizing the audit.

*Note*

* *If written confirmation is not presented at the closing conference, the auditor must send the follow-up documentation no later than 10 business days after the onsite visit.*

Audit Process:  
Post-Onsite and Reporting

The Post-Onsite and Reporting Process

The nature of post-onsite work depends on the outcome of the onsite visit. While on site, the NCQA Certified HEDIS Compliance Auditor usually finds issues that the organization can resolve before the Final Audit Report is issued. The auditor reviews and re-audits these 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 organization and NCQA in the reporting phase of the HEDIS Compliance Audit.

Corrective Actions and Reassessment

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

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

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

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| Review for sufficient corrective action | To determine if a corrective action is sufficient, the auditor reviews the following.   * Written or electronic documentation of revised numerator and denominator data and other data used in measure determinations. * Undocumented verbal communication or statements made by the organization are insufficient for completing the assessment. * The revised programming logic used in measurement computation. * The primary data source, such as claims or encounter forms, summarized claim detail, medical records or enrollment forms. The auditor may also review other primary data sources that affect the organization’s data and algorithmic integrity. |

*Note*

* *To meet the data submission deadline, all follow-up activities and corrective actions must be completed two weeks before data submission to NCQA.*

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| Determining bias | Bias is based on the degree of data completeness for the data collection method used and depends on the measure or domain. If the auditor determines that a measure is biased, the organization may not report a rate for that measure. Three assessments of bias are listed below. Refer to Appendix 9 for a list of measures and applicable assessments. |
| *Bias determination 1:* | An error causes a (+/–)5 percentage point difference in the reported rate. |
| *Bias determination 2:* | An error causes a (+/–)10 percent change in the reported rate. |
| *Bias determination 3:* | An error causes a (+/–)5 percent change in the reported rate. |
| *Bias determination 4:* | An error that causes a (+/–)10 percent change in the index hospital stays (numerator). |

Audit Results

An NCQA audit results in audited rates or calculations at the measure or indicator level and indicates whether the measures can be publicly reported. All measures selected for reporting must have a final, audited result. A measure selected for reporting or required by a state or federal program can receive a rate of *NR* if the auditor determines it is not reportable. Organizations with Medicare members must report all Medicare measures. If a measure result is *NR,* the auditor should use the comment field in IDSS to indicate the reason; the default comment indicates the rate was biased. Reporting *NR* because the organization chose not to report puts the organization at risk of noncompliance with CMS regulations. The auditor approves the rate or report status of each measure, as shown in the following table.

### For Performance Measures

| Rate/Result | Comment |
| --- | --- |
| *0–XXX* | *A rate or numeric result*. The organization followed the specifications and produced a reportable rate or result for the measure. |
| *NA* | *Small Denominator*. The organization followed the specifications but the denominator was too small (<30) to report a valid rate. |
| *NB* | *Benefit Not Offered*. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency). |
| *NR* | *Not Reportable*.   * The calculated rate was materially biased, ***or*** * The organization chose not to report the measure, ***or*** * The organization was not required to report the measure. |

### For Survey Sample Frames

| Rate/Result | Comment |
| --- | --- |
| *SR* | *Supports Reporting*. The survey sample frame was reviewed and approved. |
| *NR* | *Not Reportable.* The survey sample frame was incomplete or materially biased. |

### For WHP Measures

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| Rate/Result | Comment |
| *0–XXX* | *A rate or numeric result*. The organization followed the specifications and produced a reportable rate or result for the measure. |
| *NA* | *Small Denominator.* The organization followed the specifications but the denominator was too small (<100) to report a valid rate. |
| *NR* | *Not Reportable.*   * The calculated rate was materially biased, ***or*** * The organization chose not to report, ***or*** * The organization is not required to report. |

### For DM Measures

| Rate/Result | Comment |
| --- | --- |
| *0–XXX* | *A rate or numeric result*. The organization followed the specifications and produced a reportable rate or result for the measure. |
| *NA* | *Small Denominator*. The organization followed the specifications but the denominator was too small (<30) to report a valid rate. |
| *NB* | *Benefit Not Offered*. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency). |
| *NR* | *Not Reportable.*   * The calculated rate was materially biased, ***or*** * The organization chose not to report, ***or*** * The organization is not required to report. |

Public Reporting, Benchmarks and Accreditation

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| HEDIS data submission  to NCQA | The organization must use the NCQA IDSS to submit data to NCQA for accreditation, inclusion in the HEDIS database, public reporting or special NCQA projects.  If HEDIS data are sent to a third party (e.g., state Medicaid agency) through IDSS, the organization must submit the data to NCQA under the license agreement. If the organization does not use the IDSS to send data, the auditor must submit a record of the measure rates with the Final Audit Report for the audit to be considered a HEDIS audit.  **Note:** Data submission tools for WHP and DM are provided separately. |
| NCQA national database submission | The organization can submit its audited HEDIS data for inclusion in NCQA’s national database to:   * Contribute to national benchmarks and regional and national averages and be publicly reported through *Quality Compass*. * Contribute to national benchmarks and regional and national averages, but not be publicly reported through *Quality Compass*. * Satisfy NCQA Accreditation requirements (per the organization accreditation contract, NCQA may publicly report HEDIS measures required for accreditation). |

Final Audit Opinion and Statement *for HEDIS*

At the close of the audit, the auditor renders the Final Audit Opinion, which contains a Final Audit Statement, measure rates and comments. The Final Audit Opinion must be submitted to NCQA within 30 days after the reporting deadline.

The NCQA submission tool includes rates and comments. If the organization does not submit the submission tool, the auditor must send a list of measures, the rates and comments for each measure. The auditor must use the Final Audit Statement below and submit it to the NCQA audit coordinator electronically or on paper.

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| Final Audit Statement We have examined [*organization’s*] submitted measures for conformity with the Healthcare Effectiveness Data and Information Set (HEDIS) Technical Specifications. This audit followed the NCQA HEDIS Compliance Audit standards and policies and procedures. Audit planning and testing was constructed to measure conformance to the HEDIS Technical Specifications for all measures presented at the time of our audit.  This report is [*organization*] 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 submission presents fairly, in all material respects, the organization’s performance with respect to the HEDIS Technical Specifications. Our examination was made according to HEDIS Compliance Audit standards and policies and procedures, 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 organization.  In our opinion, [*organization*] submitted measures were prepared according to the HEDIS Technical Specifications and present fairly, in all material respects, the organization’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 HEDIS Compliance Auditor) (Date)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Responsible Officer) (Date)  Organization ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Submission ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Final Audit Opinion and Statement *for DM*

At the close of the audit, the auditor renders the Final Audit Opinion, which contains a Final Audit Statement and the DM data submission tool with measure rates and comments. The Final Audit Opinion must be submitted to NCQA within 30 days after the reporting deadline.

The auditor must use the Final Audit Statement below and submit it to the NCQA audit coordinator electronically or on paper.

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| Final Audit Statement We have examined [*organization’s*] submitted measures for conformity with the Disease Management Technical Specifications. This audit followed the NCQA HEDIS Compliance Audit standards and policies and procedures. Audit planning and testing was constructed to measure conformance to the DM Technical Specifications for all measures presented at the time of our audit.  This report is [*organization*] 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 submission presents fairly, in all material respects, the organization’s performance with respect to the DM Technical Specifications. Our examination was made according to HEDIS Compliance Audit standards and policies and procedures, 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 organization.  In our opinion, [*organization*] submitted measures were prepared according to the DM Technical Specifications and present fairly, in all material respects, the organization’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 HEDIS Compliance Auditor) (Date)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Responsible Officer) (Date)  Organization ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Submission ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Final Audit Opinion and Statement *for WHP*

At the close of the audit, the auditor renders the Final Audit Opinion, which contains a Final Audit Statement and the WHP data submission tool with measure rates and comments. The Final Audit Opinion must be submitted to NCQA within 30 days after the WHP reporting deadline.

The auditor must use the Final Audit Statement below and submit it to the NCQA audit coordinator electronically or on paper.

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| Final Audit Statement We have examined [*organization’s*] submitted measures for conformity with the Wellness and Health Promotion (WHP) Technical Specifications. This audit followed the NCQA HEDIS Compliance Audit standards and policies and procedures. Audit planning and testing was constructed to measure conformance to the WHP Technical Specifications for all measures presented at the time of our audit.  This report is [*organization*] 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 submission presents fairly, in all material respects, the organization’s performance with respect to the WHP Technical Specifications. Our examination was made according to HEDIS Compliance Audit standards and policies and procedures, 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 organization.  In our opinion, [*organization*] submitted measures were prepared according to the WHP Technical Specifications and present fairly, in all material respects, the organization’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 HEDIS Compliance Auditor) (Date)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Responsible Officer) (Date)  Organization ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Submission ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Final Audit Report *for HEDIS and DM*

When the audit is complete, the auditor prepares a plan-specific Final Audit Report. This report is a summary of all audit activities for the audited plan: audit detail is contained in the Information Systems (IS) Tool and the rate review documents.

Within 30 days of the HEDIS or DM reporting deadlines, the auditor must submit copies of the report to the organization and to NCQA, which uses it to ensure that all HEDIS audits are conducted according to guidelines. The report must provide enough plan-specific information for NCQA to evaluate and conclude that the results are supported and specific to the organization.

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| Report contents | * Licensed Organization name and address of the office responsible for the audit project. * Company officer responsible for the audit. * Audit team information: * Certified Auditor leading the audit. * Role of each team member, including dates of involvement and level of effort. * Team structure (e.g., Certified Auditor, direct reports, others). * Qualifications of each team member, including education, years of HEDIS experience and years of audit experience. * Organization information: * Organization names and addresses. * Organization and submission IDs. * Name, position and address of the individual at the organization responsible for HEDIS reporting (i.e., sign-off authority). * Locations of HEDIS report preparation activity with contact name and address for each location. * Audit information: * Product lines or products reported and a list of measures for each product. * Audit timeline (proposed and actual dates); optional auditor strategy and considerations. * Survey sample frame findings (if applicable): * Survey vendor information. * Organization’s survey reporting intentions. * Source-code-review and process results. * Reasonability checks results. * Supplemental database findings: * Policies and procedures reviewed. * Databases reviewed. * Primary source verification (PSV). * PSV exemption rationale. * Audit results. * Source code review findings: * Vendor used, if applicable. * Core set selected and results, if applicable. * Source code review results. |

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|  | * MRR validation findings: * Results and rationales for the measures selected from each group (including expansions, if applicable). * Summary of MRR process review. * Auditor findings: results of final statistical validation and a record of any corrective actions. * IS Standards compliance findings: * Summary of the auditor’s findings from the “Describe Impact on HEDIS Reporting Capability” column of the IS compliance tool (Appendix 5). * Assessment of organization performance on each IS standard and its impact on HEDIS reporting. * Final Audit Opinion, composed of: * Audit Statement. * Audit results and associated rates (e.g., a copy of the ART). |

Final Audit Report *for WHP*

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

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| Report contents | * Licensed Organization name and address of the office responsible for the audit project. * Company officer responsible for the audit. * Audit team information: * Certified Auditor leading the audit. * Role of each team member, including dates of involvement and level of effort. * Team structure (e.g., Certified Auditor, direct reports, others). * Qualifications of each team member, including education, years of WHP experience and years of audit experience. * Organization information: * Organization names and addresses. * Organization and submission IDs. * Name, position and address of the individual at the organization responsible for WHP reporting (i.e., sign-off authority). * Locations of WHP report preparation activity with contact name and address for each location. * Audit information: * Product lines or products reported and a list of measures for each product. * Audit timeline. * Summary of offsite activities, including auditor strategy and considerations. |

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|  | * IS Standards Compliance Findings: * A summary of the auditor’s findings from the Describe Impact on WHP Reporting Capability column of the IS compliance tool (Appendix 5). * Assessment of organization performance on each IS standard and its impact on WHP reporting. * Final Audit Opinion, composed of: * Audit Statement. * Audit results and associated rates (e.g., a copy of the submission tool). |

Other Reporting Requirements

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| Portability of audit opinions | Because audit accountability at the measure level is crucial to maintaining audit integrity, NCQA allows a measure’s audit result 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 (e.g., IS review, MRR validation); this includes vendor assessment. A Licensed Organization’s assessment of vendor information systems may not be transferred to another Licensed Organization. |
| Rates and results | NCQA’s standardized applications for submitting data are provided to organizations no later than April of the reporting year. The *User’s Guide* contains a description of organization and auditor responsibilities.  When the audit is complete, the organization and auditor finalize the submission tool by verifying the data, checking the Audit Tables for accuracy and completeness, locking the tool and marking the submission “final.” The organization is responsible for completing the submission tool and the Attestation Form. For version control and auditor independence, the auditor only reviews information the organization has provided in the form and may not enter it for the organization. The Audit Table must be completed by the auditor; the organization may not complete it. By approving a measure on this table, the auditor validates all activities that culminate in a rate.  Full instructions for all tasks accompany the tools. The organization finalizes the tool, completes an Attestation Form and sends it to the data submission account manager in NCQA’s Data Collection Department. |
| Final date for submission | The final date for audited HEDIS data submission to NCQA is the HEDIS reporting deadline. | |
| Audit seal | When NCQA receives and approves the Final Audit Report, it sends the audit seal directly to the organization to use for advertising and marketing. | |

*Note*

* *If the organization does not submit the submission tool to NCQA, it must give the auditor a report that records the rate. The auditor approves the reported measures and submits the report, with the Final Audit Statement, to the audit coordinator at NCQA.*
* *For Medicare submissions, the auditor reviews totals for each measure in the Patient-Level Detail File to provide assurances that the data are accurate and audited as required in the Medicare Reporting Requirements document.*

Work Papers and Documentation

Certified Auditors must retain all work papers, including the Final Audit Report submitted to NCQA. NCQA recommends that organizations and Licensed Organizations retain audit documentation for three years. At a minimum, work papers must include the documents listed below.

*Note*

* *All Licensed Organizations are required to provide* ***either****:*
* *Access to their full e-mail system,* ***or***
* *All clients’ e-mails, collected in a client folder and loaded into an Adobe PDF file, with links and attachments enabled.*

Licensed Organization Information

* Copies of all current audit contracts or letters of intent.
* Copies of all contracts with independent auditors.
* A list of all auditing and consulting activities or relationships between the Licensed Organization and audit clients or affiliates for the past three years (e.g., IS consulting, HEDIS consulting, HEDIS projects or information systems work.
* A list of all auditing and consulting activities or relationships between the employed or contracted auditors and audit clients or any affiliates for the past three years (e.g., IS consulting, HEDIS consulting, HEDIS projects or information systems work.

Organization-Specific Information

* Current health care organization and Licensed Organization information: a copy of a Final Audit Report.
* 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 organization or any organization affiliates for the past three years (e.g., IS consulting, or HEDIS consulting, HEDIS or information systems.
* Copies of all current audit contracts or letters of intent, including contracts with independent auditors.
* An audit timeline (if not already specific enough in the Final Audit Report) that includes negotiated and actual dates for at least:
* Opening meetings or conference calls.
* Receipt of Roadmap.
* Core set selection and delivery to the organization.
* Offsite data requests and subsequent deliveries.
* Onsite visits for each location.
* Offsite activities such as source code review, MRR validation, document review, conference calls.
* Follow-up documentation to the organization.
* Organization responses.
* Data submission by organization to the Licensed Organization.
* Final data submission.
* Audit correspondence (e-mail):
* All correspondence among team members.
* All correspondence between auditors and the organization.

Offsite Activity Files

* The Roadmap papers:
* The Roadmap as executed by the organization and certified software vendor, if applicable.
* A paper or electronic copy of the Roadmap Attestation, with the appropriate signature and date.
* Auditor notes from reviewing the Roadmap, including all preliminary issues and items to discuss before or during the onsite visit.
* All requested documents.
* All documents received from the organization (before the onsite visit) and auditor’s notes and analysis for each, including whether the issue is resolved or is under discussion.
* Survey sample frame files:
* Source code (if appropriate) and sample files with content.
* Source code review results (e.g., HD grids for the survey).
* Results of the survey sample frame analysis, including statistics (e.g., on age, gender, flags).
* Survey Sample Frame approval documents.
* MRR validation:
* Organization documents supporting the MRR process, including training and abstraction instructions.
* Organization documents and reports describing quality oversight, including interrater reliability checks, rater-to-standard tests or any other quality control programs, and the staff subject to each version of quality control.
* Documents describing tool review and results.
* Documentation of convenience sample determination, or why a convenience sample was not used.
* Documents describing an exemption from MRR validation, if applicable.
* Systematic sample source code and HD grids.
* Documents describing the logic and rationale used to determine the MRR validation selections (plans, product lines and measures).
* Documentation of the MRR validation process, including the validation process (where, when and by whom); the numerator positive counts and the list of selected records; the results of the medical records reviewed; and the T-test and results, if appropriate.
* Documentation describing assessment of appropriate medical record substitution.
* Final statistical validation notification.

***Note:*** *NCQA does not require data or charts for each plan selected for review, but reserves the right to request data or charts used in MRR validation, selected at random from an auditor, plan or measure. NCQA will notify the practice leader of this request when the list of selected plans is provided. Data or Medical records collected as a part of the documentation above may be destroyed after the monitoring visit.*

* Source code review:
* If the organization does not use certified software, or for measures not covered under certification, the auditor’s review notes (including reviewers, location, work dates and level of effort) and source code review reports for:
* Repository creation and extraction programs.
* MRR entry and transfer programs.
* Core set selection documents including rationales and results.
* HEDIS Determination documents for each measure in the core set, and measures in any expansion of the core set, with reference to applicable HD standards and comments on the compliance with each standard.
* For plans with certified software or ASCR, HEDIS Determination documents for each measure not covered in the Software Certification Report.
* Certified Software Vendor’s Final Certification Report, if applicable.
* Documents that validate activities for measures where the certified software vendor status was *Pass With Qualifications* or *Fail.*
* Supplemental database findings:
* A complete list of all databases, including type, process, measures affected, applicable incentives, issues and findings.
* Source code (if appropriate).
* Source code review results.
* Policies and procedures documents.
* Data mapping and integration assessment.
* Sample files with format and content information (samples only).
* Primary source verification (PSV) notes, results or exemption rationale.

***Note:*** *NCQA does not require PSV files with data or charts for each plan selected for review, but reserves the right to request the data or charts used for the supplemental database validation, selected at random from an auditor, plan or measure. NCQA will notify the practice leader of this request when the list of selected plans is provided. Data or charts collected as a part of the documentation above may be destroyed after the monitoring visit.*

* Interim versions of the IS standards compliance tool (refer to the sample in Appendix 5).
* Audit correspondence (e-mail):
* All correspondence among team members.
* All correspondence between auditors and the organization.

Onsite Activities

* A participant sign-in sheet, including the participant name, the date and the location. Onsite participants must sign the sheet; participants who phone in may be listed.
* A complete record of onsite activities, including agenda, participants and supplements to the Roadmap.
* Comprehensive interview and demonstration notes or tools with participants, dates and times of sessions, other participants present during sessions and any issues discovered during the session.
* A summary of the visit, including follow-up documentation and follow-up requirements with target dates.
* Interim versions of the IS standards compliance tool with preliminary audit findings (indicate measures at risk).
* Copies of documents collected on site; photos or scanned versions are acceptable. Alternatively, onsite papers may be uploaded to the Licensed Organization’s FTP site, but papers should be clearly marked as pertaining to the onsite visit.

Audit Result Files

* Standard compliance tools:
* A final, organization-specific IS Standards Compliance Tool, with auditor’s notes on the adequacy of data collection, storage and manipulation of key files to produce accurate measures. It must also contain documentation of issues, resolutions, possible problem areas, comments on compliance with each standard as it affects measure 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 or last year comparison, benchmark comparison, auditor’s notes, questions and requests for additional information.
* The organization’s response to preliminary submission tool issues and rates.
* Final rate submission tool with organization and auditor notes and final auditor approval.
* Final locked submission, including the Audit Review Table.
* Audit correspondence (e-mail):
* All correspondence among team members.
* All correspondence between auditors and the organization.

The NCQA monitoring program includes a review of these papers and ensures adherence to program policies and procedures. Licensed Organizations must provide a complete set of work papers for review