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**MY 2007 P4P Manual**
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Introduction

Background

The clinical quality measures can be found in the P4P Integrated Healthcare Association California Pay for Performance Program: 2007 Measurement Year Manual and should be used with this document. The clinical measures are adapted from the National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS®), the most widely used set of performance measures in the managed care industry. NCQA is a not-for-profit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

P4P also includes an audit review to ensure that results are an accurate report of Physician Organization (PO) performance. The audit review of the clinical measures is based on NCQA’s HEDIS Compliance Audit™ program. NCQA staff worked with P4P participants in 2003 to incorporate the relevant components of the HEDIS Compliance Audit and to adapt policies and procedures where necessary.

Because this program is an adaptation, it is not considered a HEDIS Compliance Audit, but a Pay for Performance Audit Review. This manual includes the information needed to collect, report and conduct an audit review of the clinical measures included for the P4P reporting initiative.

Contents of This Manual

Audit Review for Health Plans
This section contains information on additions to the audit process for health plans reporting P4P data on behalf of POs.

P4P Audit Standards for POs
This section includes the HEDIS Compliance Audit Standards that apply to the P4P data.

Audit Review for POs
This section includes all components of the audit review for POs, including an overview, audit standards and a detailed description of the audit review process.

Appendices
These sections contain P4P PO audit review documents, including the PO Baseline Assessment Tool, a data source documentation checklist, decision point grid, IS standards compliance tool and a glossary.

If You Have Questions About the P4P Program

NCQA Policy Clarification Support
NCQA’s Policy Clarification Support (PCS) system provides policy support to P4P stakeholders by allowing them to submit their specific policy interpretation questions to NCQA staff. The PCS system is on the NCQA Web page at www.ncqa.org.

To access the PCS, select Support at the left side of the Web page and click on Policy Clarification Support. For P4P questions, choose HEDIS: IHA Pay for Performance (P4P) in the Measures/Standards dropdown box. The direct URL for the PCS main menu page is www.ncqa.org/pcs.

Frequently Asked Questions
Frequently Asked Questions (FAQ) clarify P4P specifications. NCQA posts FAQs to its Web site on the 15th of each month. P4P groups should refer to the following link on the NCQA Web site: http://app04.ncqa.org/faq/. Select the IHA P4P product.
P4P Audit Review for Health Plans
# Modifications to Health Plan HEDIS Compliance Audit

## Enrollment in the PO
The Certified Auditor must confirm that the health plan appropriately calculated enrollment at the PO level as specified in the P4P General Guidelines. As part of this process, the Certified Auditor assesses if the health plan accurately maintains associations between the member and the PO.

## Medical record data
The Certified Auditor must confirm that medical record review was not used to collect P4P data.

## Encounter threshold
The Certified Auditor must validate that the health plan correctly calculated PO PMPY encounter rates according to the specification included in the P4P General Guidelines to ensure correct application of the encounter threshold specification.

## Baseline Assessment Tool (BAT)
The Certified Auditor may request additional detailed information about the health plan’s processes for generating the measure results by PO.

## Source code review
The Certified Auditor must conduct source code review for all uncertified P4P measures. Health plans must use the clinical specifications in the *P4P Integrated Healthcare Association California Pay for Performance Program: 2007 Measurement Year Manual*. If the plan uses certified HEDIS software or certified P4P software, auditors must review all additional steps, especially the attribution of results to individual POs, and workarounds used to generate the P4P measures.

## Benchmarks and thresholds
The Certified Auditor must validate the reasonability of the PO data reported by the P4P health plans by:

- Comparing PO rates reported in the current reporting year to, at least, those reported in prior P4P reporting year.
- Comparing mean PO rates to the plan’s HEDIS administrative rates.

## Other Data Checks
The following are general checks:

- Compare ENCRATE denominator to Total Group Enrollment for similarity.
- Check the PO Master list to ensure all groups are reported.
- Check that the rate column = numerator column/denominator column
- Ensure that no rate is > 100%.
- Compare P4P Total Enrollment to total plan enrollment.
- Check each P4P ID/Sub ID file for 1 for record for each clinical group and 2 ENCRATEs.
- Check that each rate field has 5 digits after decimal and no rounding.

These are measure-specific edits you can perform:

- Chlamydia Screening: ensure the sum of the denominators and numerators of each age groups adds up to the totals for the overall age group.
- Ensure the denominators for CIS, CMC and CDC are the same for all reported numerators for each measure.
- Ensure that the sum of all PO denominators for a specific measure is equal or less than the health plan’s HEDIS eligible member population.
Compare the following rates:

- The P4P current rate to the HEDIS current rate.
- The P4P current rate to the P4P rate in the prior year.
- The P4P current rate to the P4P NCQA plan-level percentiles and thresholds.
- For new measures, compare the P4P current rate to prior year’s HEDIS administrative rate.

**Audit results**

The P4P Audit Review results in audited rates or calculations at the measure level and indicate if the measures can be publicly reported. All measures selected for reporting must have a final, audited result. A measure selected for reporting by a PO can receive a rate of NR if the auditor determines it is not reportable.

For P4P MY 2007 measures only

<table>
<thead>
<tr>
<th>Rate/Result</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–XXX</td>
<td>Reportable measure</td>
<td>Rate for P4P measure</td>
</tr>
<tr>
<td>NA</td>
<td>Not Available</td>
<td>The health-plan-calculated PO encounter rate did not meet the PMPY threshold.*</td>
</tr>
<tr>
<td>NB</td>
<td>No Benefit</td>
<td>The MCO did not offer the health benefit required by the measure (e.g., pharmacy)</td>
</tr>
<tr>
<td>NR</td>
<td>Not Reportable</td>
<td>The measure was calculated, but the rate was materially biased.</td>
</tr>
<tr>
<td>NC</td>
<td>Not Collected</td>
<td>For testing and transition measures only, the reporting entity did not report the measure, audit optional.</td>
</tr>
</tbody>
</table>

* This assessment is done by health plans only. A PO that does not meet the threshold at the health plan is assigned this rationale for all the P4P measures for that health plan. The per member per year (PMPY) threshold will be determined and communicated later in 2007.

**Note:** Transition and testing measures will not receive an audit result. These measures are collected in 2008, but not audited.

**Note:** For measures reported as a rate, **materially biased** is any error that causes a (+/-) 5 percentage point difference in the reported rate.

**Data submission**

The final date for audited P4P data submission to NCQA’s subcontractor, Diversified Data Design Corp. (DDD), is shown on the “Data Collection and Reporting Timeline” in the P4P General Guidelines. The timeline also shows the date when DDD provides the standard format for submitting data.

The auditor will approve the health plan’s data submission file to DDD, which will include all data elements defined in the data submission file specifications.

**Final Audit Opinion**

At the close of the audit, the auditor renders the Final Audit Opinion. The Final Audit Opinion contains an Audit Review Statement for P4P data. The Final Audit Opinion for P4P must be submitted to NCQA no later than 30 days after the HEDIS commercial reporting deadline.

**Final Audit Report**

When the audit is complete, the auditor prepares a Final P4P Audit Review Report, which includes the Summary Report, the IS Assessment and Findings for all POs. The auditor must submit copies of the report to the health plan and to NCQA, which uses it to evaluate the audit process and ensure that all audits are conducted according to guidelines.

The report must provide enough information for NCQA to evaluate and conclude that the rates and audit results are supported by the work that was done. The
Final Audit Opinion for P4P must be submitted to NCQA no later than 30 days after the HEDIS commercial reporting deadline.

The template for the Audit Review Statement is below. The auditor must submit this document electronically to the audit department at NCQA. There is only one Audit Review Statement for all P4P PO-level data the plan provides.

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**Health Plan P4P Audit Review Statement**

We have examined MY 2007 submitted measures of [Health Plan Name]'s for conformity with the Integrated Healthcare Association Pay for Performance Program: P4P MY 2007 Clinical Measure Specifications and the P4P MY 2007 Audit Review Guidelines. Our audit planning and testing were constructed to measure conformance to the P4P MY 2007 Manual (health plan sections only) for all measures presented at the time of our audit.

This report is the [Health Plan] management’s responsibility. Our responsibility is to express an opinion on the report based on our examination pursuant to the audit guidelines established in the MY 2007 P4P Manual. Our examination included procedures necessary to obtain reasonable assurance that the MY 2007 submitted measures were generated according to the P4P MY 2007 Manual, and accordingly included procedures we considered necessary to obtain a reasonable basis for rendering our opinion. Our opinion does not constitute a warranty or any other form of assurance as to the nature or quality of the health services provided by or arranged by any of the participating Provider Organizations (PO), the adequacy of the PO information systems, or the PO policies and procedures for submission of data to the Health Plan.

In our opinion, MY 2007 submitted measures of [Health Plan Name] were prepared according to the P4P MY 2007 Manual and presents fairly, in all material respects, the Health Plan’s adherence to these specifications.

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

________________________________________  ____________________________
(NCQA-Certified HEDIS Auditor) (Date)

________________________________________  ____________________________
(Responsible Officer) (Date)

Organization ID: ________________________________
Submission ID(s): _______________________________

---

**Audit review work papers**

In addition to the Final Audit Report submitted to NCQA, Certified Auditors must retain additional work papers related to the P4P audit review that are available on request for monitoring purposes. The NCQA monitoring program includes a review of these papers and ensures adherence to program policies and procedures. Work papers also include all relevant documentation completed, requested or reviewed during the P4P audit review.

For a complete list of documents, see HEDIS 2008 Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.
P4P Audit Standards for POs
Overview

P4P Audit Review Standards for POs are derived from NCQA’s HEDIS Compliance Audit Standards, the foundation on which Certified HEDIS Compliance Auditors assess a health plan’s ability to report HEDIS data accurately and reliably. These standards represent key processes involved in P4P clinical data collection and reporting.

This section includes the standards and assessments that apply to POs that self-report the P4P clinical data, and which are a derived subset of the HEDIS Compliance Audit Standards that health plans must meet during HEDIS audits.

Standards are divided into two sections:

<table>
<thead>
<tr>
<th>Information System (IS) standards used in P4P Audit Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Because P4P clinical data depend on the quality of the PO’s information systems, the <strong>IS standards</strong> measure how the PO collects, stores, analyzes and reports medical, service, member and vendor data. A PO unable to process health care data cannot accurately and reliably report P4P clinical information. The standards specify the minimum requirements that information systems should meet, and criteria that the manual processes used in P4P clinical data collection must meet. The audit review assesses the IS standards and ensures that the PO has effective systems information practices and control procedures for reporting P4P clinical data.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Determination (HD) standards used in P4P Audit Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>The <strong>HD standards</strong> are the foundation on which auditors assess P4P clinical data compliance (i.e., if a PO adhered to specifications). The standards describe specific information that the auditor should look for, such as proper identification of denominators and numerators and verifying algorithms and rate calculations. Auditors must take into account PO compliance with the IS and HD standards to fully assess P4P reporting capabilities. To verify compliance with these standards, NCQA requires that all applicable items be evaluated during an initial audit engagement.</td>
</tr>
</tbody>
</table>


Information System Standards

IS 1.0 Sound Coding Methods for Medical Data

IS 1.1 Industry standard codes (e.g., ICD-9, CPT, DRG, HCPCS) are used consistently and all characters are collected and captured.

IS 1.2 Principal codes are identified and secondary codes are captured. Nonstandard coding schemes are fully documented and mapped back to industry standard codes.

Explanation

The PO must capture all clinical information pertinent to the delivery of services to provide a basis for calculating P4P measures. The audit process ensures that the PO consistently captures sufficient clinical information. Principal among these practices, and critical for computing P4P clinical measures, is consistent use of standardized codes to describe medical events, including nationally recognized schemes to capture diagnosis and procedure codes such as DRG.

Standardized coding improves the comparability of P4P measures through common definition of identical clinical events. The PO must cross-reference any nonstandard coding schemes it uses at the specific diagnosis and service level to attain equivalent meaning with codes specified in each of the measures.

Assessment

The Certified Auditor verifies the following, as appropriate:

- Principal data submission documents and files used to collect transaction data use industry standard codes with full character levels
- Data entry processes preserve full entry of codes
- Data entry screens allow for all principal and secondary codes required for measure reporting
- Codes for medical events (diagnoses, procedures, prescriptions, etc.) are complete, accurate and specific in describing the service
- Coding conventions are maintained in any measure repository used to compute the final numerators and denominators
- All nonstandard codes and coding systems are identified and fully documented with a computer-based file defining the mapping
- The PO enforces data submission policies

Auditor reviews claims/encounter...

- Data entry screen file layouts
- Data submission policies
- Nonstandard coding descriptions
- P4P reporting claims/encounter repository file layout
- Descriptive documentation of claims/encounter third-party code
- Files used to collect claims/encounter transaction data electronically
- Documents that map nonstandard codes to standard codes
Software Certification

The auditor is required to assess compliance with this standard. No item is affected by software certification.
IS 2.0 Data Capture, Transfer and Entry—Medical and Service Data

IS 2.1 Standard submission forms are used routinely and capture all fields relevant to P4P clinical reporting. All proprietary forms capture equivalent data.

IS 2.2 Data receipt and entry processes are effective and efficient, and ensure timely, accurate and complete input to P4P clinical reporting.

IS 2.3 Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, sign-off).

IS 2.4 The PO assesses data completeness on an ongoing basis and takes steps to improve its performance.

Explanation

The integrity of clinical and service measures requires using standard forms, controlling receipt processes, editing and verifying data entry and implementing other control procedures that promote accuracy in receiving and recording medical and service information. The transfer of information from medical records and other data sources into the PO's databases must be subject to the same standards for accuracy and completeness.

Assessment

The Certified Auditor verifies, as appropriate:

- Standard submission forms are used for all medical data (CMS 1500 and UB92/04)
  - If the PO uses proprietary submission forms, determine the extent to which equivalent data are collected and assess the potential impact on measure reporting

- Data fields resulting from electronic claims/encounter transmission are consistent with industry standard forms; electronic replacement of proprietary forms provides equivalent data
  - If applicable, assess the potential impact

- The PO collects, at a minimum, all data fields listed in the PO BAT, whether or not the collection is by standard or proprietary forms or their electronic equivalents

- Screens receive all required data
  - Examine documentation and observe entry operations

- Proper edit checks (parity checks, field sizes, date ranges, cross checks with member file, cross checks with practitioner file, code ranges, practitioner services by specialty) detect data entry errors

- Data transaction files are accurate
  - Examine a sample of data-entry files and compare them to source documents
  - Examine PO procedures for ensuring accuracy

- Standard and nonstandard contracts require data for P4P reporting and provide for inspection and onsite auditing of data, correction and resubmission of data and backlog control standards and procedures

- The PO provides data on volume of input by type
  - View receipt logs and file counts and test counts against expected volumes

- Data extraction and consolidation processes ensure that the measure repository accurately reflects the transaction files

- The PO's use of electronic formats and data transmission protocols are correct, and it documents the industry, national and ISO standards for health care Electronic Data Interface (EDI)
• Procedures ensure that transmissions are properly controlled by logs, record count verification, redundancy checking, receipts, retransmissions and sign-offs

• Examine edit checks on internal administrative database entry screens

• The PO implements data completeness studies
  – Review all activities that assess or improve data completeness

**Auditor reviews claims/encounter and other data documents...**

- Data edit lists, including an explanation of all edit failures and accompanying messages
- Electronic file formats and protocols
- Electronic transmission procedures and receipt logs
- Operator performance standards and reports that display for each operator
- Processor accuracy and productivity for a given (and relevant) period
- System and data flow charts that describe the processes in pseudo code format
- System modification process, checks, and results (if applicable)
- Transaction files
- Instructions for submitting electronic claims/encounter files
- Medical data claims/encounter submissions
- Forms, including samples of completed forms and policies, procedures and instructions for filling out claims/encounter forms
- Log forms for submission and receipt of data (manual and electronic)
- Files used to collect claims/encounter transaction data electronically.

**Manuals...**

- Data integration policy and procedure manuals for claims/encounter processing
- Provider data integration policy and procedure manuals for claims/encounter processing
- Training material and procedure manuals for claims/encounter entry and data entry staff.

**Other documents...**

- Policy and Procedure documents for supplemental databases
- Content of transaction files and the P4P reporting repository
- Implementation of the control procedure
- Samples of field-by-field comparison of original and receiving files
- Standard monitoring reports for all claims/encounter operations personnel, including data entry, claims/encounter processing staff and hardware operations
- Descriptive documentation for claims/encounter data entry, data transfer, data manipulation programs and processes
- Record and file formats and descriptions for entry, intermediate and repository files
- Data completeness studies
Software Certification

The auditor is required to assess compliance with this standard. No item is affected by software certification.
IS 3.0 Data Capture, Transfer and Entry—Membership Data

IS 3.1 The PO has procedures for submitting P4P clinical measure-relevant information for data entry and for ensuring accurate, complete and timely entry of membership data.

IS 3.2 Data entry processes are effective, efficient and timely, and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.

IS 3.3 Electronic transmissions of membership data have necessary procedures to ensure accuracy.

Explanation

Controlling receipt processes, editing and verifying data entry and implementing other control procedures to promote completeness and accuracy in receiving and recording member information are critical in databases that calculate P4P measures. Specific member information includes age, gender, benefits, product line and the dates that define periods of membership, so gaps in enrollment can be determined.

Assessment

The Certified Auditor verifies the following, as appropriate:

- The PO’s system accommodates changes in family status and insurance coverage.
- The PO’s system accommodates methods for defining start and termination of coverage and properly reports the member in member, month and age categories with P4P and non-P4P plans.
- The PO’s system accommodates multiple membership status changes, including membership periods and disenrollment information across multiple plans
  - Ensure that required information is not lost
- Screens can receive all required P4P clinical data
  - Examine documentation and observe data entry operation
- Member file computations can accurately support measure requirements, such as continuous enrollment, age and sex designations and assignment of members to health plans and to product lines or products
- The PO has mechanisms for transferring information from health plans to appropriate PO locations
  - Review pre-entry and entry processes, entry accuracy, corrections and issues of membership data
- All data entry operations are consistent
  - Compare processed documents and electronic input to the corresponding file contents
- Software has proper edit checks to detect data entry errors (parity checks, field sizes, date ranges, cross checks with practitioner file, code ranges, rules for unique identification and key/verify processes, etc.)
- Data extraction and consolidation processes ensure that the measure repository reflects data entry files
  - Perform a field-by-field comparison of the original to repository
- The PO correctly uses electronic formats and data transmission protocols and documents the industry, national and ISO standards for health care EDI that it uses
- The PO uses control procedures and protocols
- Transaction files contain the submitted information
  - Verify that data fields are the appropriate size for receiving the data
Auditor reviews eligibility/membership data...

- Data entry logs, screens and processes
- Data edit lists that display and explain all edit failures and the messages that accompany them
- Electronic formats, protocols and electronic transmission procedures
- Log forms for submission and receipt of data (manual and electronic)
- Operator performance standards and reports
- Processor accuracy and productivity for a given (and relevant) period
- Record file formats and descriptions for entry, intermediate and repository files
- System and data flow charts that describe the processes in pseudo code format
- System modification process, checks and results (if applicable)
- Transaction files
- Files used to collect data electronically

Other documents...

- System modification documentation, if applicable
- Documentation of PO mechanisms for electronic transfer of information that verify sound procedures are in place to ensure transmissions are properly controlled by logs, record count verification, redundancy checking, receipts, retransmissions and sign-offs
- Copies of standard monitoring reports for membership data operations personnel, including data entry, member file clerical staff and hardware operations
- Data entry of membership updates
- Documentation for membership data entry, data transfer and data manipulation programs and processes
- Training materials and procedure manuals for membership data entry staff

Software Certification

The auditor is required to assess compliance with this standard. No item is affected by software certification.
IS 4.0 Data Integration Required to Meet the Demands of Accurate Measure Reporting

IS 4.1 Data transfers to measure repository from transaction files are accurate.

IS 4.2 File consolidations, extracts and derivations are accurate.

IS 4.3 Repository structure and formatting are suitable for P4P clinical measures and enable required programming efforts.

Explanation

Calculating P4P clinical measures requires data from a number of different sources. The systems used to assemble the data and make the required calculations should be carefully constructed and tested.

Assessment

The Certified Auditor verifies the following, as appropriate:

- The PO uses accurate procedures for populating its P4P measure database/repository from the transaction files (of medical, supplemental and membership data)
  - Auditors also verify completeness and accuracy by comparing data samples from repository and transaction files
- The PO has processes that consolidate information from multiple transaction files
  - Assess their ability to produce the intended result and the effectiveness of such consolidations by comparing actual results to expected results according to the documented algorithms
- The repository can accurately perform analyses and report preparation. Review program flow charts and code to assess this ability
- The repository can accommodate analyses that produce measure results
  - Review repository design and assess this ability
- Proper mechanisms are used to link data across all data sources to satisfy P4P clinical data integration requirements (e.g., identifying a member with a given disease/condition)

Auditor reviews measure repository documents...

- Measure repository computer operations and system security schemes
- Standard monitoring reports for all measure repository operations personnel, including data entry, IS staff and hardware operations
- Measure repository data entry, data transfer and data manipulation programs and processes
- Measure repository edit lists that display and explain all edit failures and their accompanying messages
- Measure repository electronic formats, protocols and electronic transmission procedures
- Measure repository manuals covering application system development methodology, database development and design and decision support system use
• Measure repository record and file formats and descriptions for entry, intermediate and repository files
• Measure repository source code data-entry, data-transfer and data-manipulation programs and processes
• Measure repository system and data flow charts that describe the processes in pseudo code format
• Measure repository system modification processes, edits and results (if applicable)
• Measure repository training material and procedure manuals for operator staff

Software Certification

For an organization using NCQA-Certified software, the auditor must assess compliance with IS 4.1 and IS 4.2 because these tasks most often occur at the organization. If the software vendor maintains a repository, documents describing the repository structure are included with the BAT. The link mechanisms and analysis code are tested as part of the software certification program.
IS 5.0 Control Procedures That Support P4P Clinical Data Reporting Integrity

IS 5.1 Report production is managed effectively and operators perform appropriately.

IS 5.2 P4P clinical reporting software is managed properly with regard to development, methodology, documentation, revision control and testing.

IS 5.3 Physical control procedures ensure P4P clinical data integrity such as physical security, data access authorization, disaster recovery facilities and fire protection.

Explanation

The PO’s quality assurance practices and back-up procedures serve as an organizational infrastructure that supports all PO information systems. Practices and procedures promote accurate and timely information processing and data protection in the event of a disaster. Data needed to calculate P4P clinical measures confirm the PO’s information systems and may be directly or indirectly affected by information system practices and procedures.

Assessment

The Certified Auditor verifies the following, as appropriate:

- The PO has adequate documentation governing the production process
- The PO has production activity logs compliant with documented standards and schedules
- The PO has report run controls that are properly reviewed and scrutinized
- The P4P clinical data are uncompromised by deficits in physical security, data access authorization, disaster recovery procedures, power failures, fire or smoke (if data have been compromised, determine the impact on P4P measure reporting)
- The PO has adequate procedures to properly control and protect the measure repository and systems
- The PO has documented standards for all aspects of the P4P reporting repository, including building, maintaining, managing, testing and reporting
- The PO’s processes and documentation comply with report program specifications, code review methodology and testing
- The PO has adequate data update cutoff dates with regard to data reporting
- The PO retains copies of all files and databases used for reporting so reported results can be reproduced

Auditor reviews manuals...

- Covering application system development methodology, database development and design and decision support system utilization
- Describing procedures for monitoring control and security hardware function, capacity, physical states and access
Other documents…

- Computer operations and system security schemes
- Standard monitoring reports for all control and security operations personnel, including data entry and hardware operations
- Edit lists that display and explain all edit failures and the messages that accompany them
- Electronic formats and protocols
- Electronic transmission control and security procedures
- Log forms for all system control and security hardware activities, including backup, failure response and recovery and system optimization techniques
- Control system processes, including flow charts and codes for backups, recovery, archiving and other control functions
- Control and security system modification processes, edits and results, if applicable

Software Certification

As part of compliance with IS 5.0, if the organization uses NCQA-Certified software, this information is included in the vendor’s portions of the BAT. The organization and auditor must discern the appropriate version of software was used to produce the HEDIS results. The auditor must assess compliance with IS 5.1–IS 5.3.
**P4P Measure Determination Standards**

**HD 1.0 Denominator Identification**

<table>
<thead>
<tr>
<th>HD 1.1</th>
<th>Members and service events are correctly categorized into member subgroups.</th>
</tr>
</thead>
<tbody>
<tr>
<td>HD 1.2</td>
<td>Relevant medical and service events are correctly considered in terms of time and services.</td>
</tr>
<tr>
<td>HD 1.3</td>
<td>Membership parameters and continuous enrollment are correctly computed as defined by the P4P Manual.</td>
</tr>
<tr>
<td>HD 1.4</td>
<td>Other relevant data are correctly processed.</td>
</tr>
</tbody>
</table>

**Explanation**

Because P4P measures are population based, it is critical that the PO properly identifies members who are candidates for the service or event being measured. Determining the eligible population typically involves identifying all members who satisfy certain criteria related to age, gender, periods of membership in the PO and P4P plans, product line or product (i.e., commercial HMO/POS) and procedures or diagnoses within certain time frames.

**Assessment**

The Certified Auditor verifies the following, as appropriate:

- The PO’s age calculation demonstrates proper use of mathematical operations that determine member age or age range from date of birth
- The PO properly adheres to the measure time-frame requirements for periods of membership or time frames for medical services
- The PO accurately determines continuous enrollment in the specified period, including any allowable gaps in enrollment followed by reenrollment in the PO
- The PO properly identifies events that require linking visit codes, procedure codes and practitioner type codes
- The PO accurately determines enrollment with the P4P plans as of the date specified in the measure
- The PO’s system for counting member months and other membership variables ensures a complete and unduplicated counting methodology for all measures
- Patient registry data is consistent with measure specifications (such as state immunization registries)
- Supplemental databases used adhere to all P4P requirements
- All members, whether they received services or not, are included in the initial population from which denominator populations defined by measure specifications are produced
- The PO captures accurately each claim’s initial date of receipt
- The PO applies age and gender criteria appropriately
- The PO maps nonstandard codes if required codes are not present
- The PO properly identifies events that require matching claims/encounter and pharmacy data (e.g., events defined in the HbA1c Screening rate from the Comprehensive Diabetes Care measures)
- The PO properly identifies claims/encounter dependent events (e.g., events defined in the LDL Screening rate from the Cholesterol Management After Acute Cardiovascular Events measure)
The health plans and product lines/products in which members are enrolled are identified and reported appropriately.

**Auditor reviews denominator events...**
- Records based on transaction data, including claims/encounter, laboratory, radiology and pharmacy data.

**Other documents...**
- Printouts or data output of supplemental data files
- Source code and output files for reporting measures.

### Software Certification

If the organization uses NCQA-Certified software, the auditor should review the vendor’s Certification Report. The auditor should not review the denominator identification logic for measures with a *Pass* status.

If any measure received a *Pass With Qualifications* status, the auditor should review the Certification Report to determine the reasons for this status and any organization or vendor workarounds to assess if there is material bias in the organization’s denominator or eligible population.

If any measure received a *Fail* status, the auditor must evaluate the process used by the organization or vendor to produce the results. The auditor must review all source code associated with measures not included in the Certification Report.
HD 2.0 Numerator Identification

HD 2.1 Qualifying medical and service events are evaluated correctly in terms of time and services.

HD 2.2 Claims/encounter, membership and vendor data are analyzed properly in assessing numerator qualifications.

Explanation

For each denominator event, the PO determines if a numerator-qualifying event has occurred. Determinations should be based on numerator specifications. Acceptable numerator data sources include administrative data (including acceptable third-party data) containing proper codes in proper time frames or electronic medical record data that meet stated criteria. The auditor examines the data and the processes to determine if the PO accurately includes all numerator events and excludes those that did not meet the criteria.

Assessment

The Certified Auditor verifies the following, as appropriate:

- The PO’s programming appropriately identifies specified medical and service events (diagnoses, procedures, prescriptions, date of claims payment, etc.)
- The PO complies with the specified time frames, including periods of membership or time frames for medical services and service events
- The PO accurately identifies and computes multiple numerator events (e.g., events defined in the Childhood Immunization Status measure)
- The PO’s use of proprietary codes is consistent, complete and reproducible, if applicable
- Supplemental databases used adhere to all P4P requirements

Auditor reviews numerator events…
- Numerator events based on transaction data, including claims/encounter, laboratory, radiology and pharmacy data

Other documents…
- Printouts or data output of supplemental data files
- Source code and output files for reporting measures

Software Certification

If the organization uses NCQA-Certified software, the auditor should review the vendor’s Certification Report. The auditor should not review the logic for measures that received a Pass status.

If any measure received a Pass With Qualifications status, the auditor should review the Certification Report to determine the reasons for the status and review any organization or vendor workarounds to assess if there is material bias in the organization’s numerator. If any measure received a Fail status, the auditor must evaluate the process used by the organization or vendor to produce a numerator.

The auditor must review all source code associated with measures not included in certification.
HD 3.0 Algorithmic Compliance

HD 3.1 Rate calculations are arithmetically correct and are made with acceptable levels of precision.

Explanation
Algorithmic compliance addresses arithmetic used to produce measure rates and ensures that each event is counted only once. Calculations such as rates and member months must be verified.

Assessment
The Certified Auditor verifies the following, as appropriate:
- Numerator and denominator counts are accurately entered into the submission tool, as well as ratios and confidence intervals. Document confidence intervals that are below 95 percent
- Auditor reviews documents…
  - Calculation code
  - Output and rate calculation input
  - Last year’s submission tool
  - Last year’s Final Audit Report

Software Certification
The auditor is required to assess compliance with this standard. No item is affected by software certification.
HD 4.0 Documentation

**HD 4.0** Data and processes used to collect, calculate and report P4P clinical measures are completely and accurately documented.

**Explanation**

Annual P4P clinical results cannot be verified unless the PO can produce adequate documentation of the data and processes used to prepare its P4P clinical reports. An adequate “audit trail” describes the preparation process from beginning to end and includes a project plan, programming specifications, source code, computer queries, sample lists, validation summaries and many other documents. While staff interviews can provide supplementary information, the bulk of the auditor’s decisions are based on the documentation available.

**Assessment**

The Certified Auditor verifies that documentation meets the following criteria, as appropriate:

- Includes programming specifications, work flow diagrams, data sources and diagram or narrative descriptions
- Includes results of statistical tests and corrections or adjustments made to the data, with rationale
- Includes information about the year prior to the reporting year (if applicable)
- Includes dated job logs or computer runs for denominators and numerators with record counts for each programming step and iteration
- Includes the original universe of data with member-level identifiers that can be used to validate the entire programming logic for creating denominators and numerators
- Includes sources of any supporting external data or prior year’s data used in reporting
- Includes computer queries, programming logic or source code used to create final denominators and numerators and interim data files
- Shows data and processes used for individual performance indicators (or groups of indicators prepared using similar methods and types of data)
- Shows data requirements, issues, validation efforts and results, including detailed definitions and mapping to standardized data formats

**Auditor reviews documents…**

- A description of software or programming languages used to query each database
- Detailed (line-by-line) programming or administrative query procedures
- Source code and output files for core set measures
- All previously described documents

**Software Certification**

If the organization uses NCQA-Certified software, this documentation may be collected with the vendor’s portion of the BAT. The auditor does not collect source code for measures with a *Pass* status.
HD 5.0 Outsourced or Delegated P4P Reporting Function

HD 5.1 If the PO delegates any aspect of P4P clinical data collection or reporting to an external vendor, the data from the vendor meets all applicable Audit Review standards.

HD 5.2 The PO regularly monitors vendor performance against expected performance standards.

HD 5.3 If aspects of P4P clinical data collection or reporting are delegated to multiple vendors, the PO coordinates the activities of the vendors to safeguard the integrity of P4P clinical data.

Explanation

A vendor can help the PO by efficiently collecting and calculating P4P measures; however, the PO remains accountable for the accuracy of all processes that collect and report P4P clinical data. The PO should assess work performed by outside vendors to ensure its accuracy, and vendors should provide documentation of any programs or processes used to generate, collect or calculate P4P measures to the PO and auditors in a timely manner.

Assessment

The Certified Auditor verifies the following, as appropriate:

- The PO ensures that encounter-level data (laboratory, pharmacy data from plans, radiology) from vendors are accurate and complete
- The PO communicates and enforces data quality standards for contracted vendors
- The PO periodically reviews and measures vendor performance against quality/timeliness standards
- Vendor processes support P4P clinical data specifications
- The PO requires data submission from vendors on a timeline consistent with P4P reporting periods
- Data flow among vendors does not impede the accuracy or timeliness of measure reporting
- The PO verifies that no data necessary for P4P reporting are lost or inappropriately modified during transfer among vendors
- The PO requires third-party or carve-out vendors to provide data that are accurate and reliable for computing P4P measures
- Vendor errors and deficiencies are addressed completely and in a timely manner (before measure reporting)

Auditor reviews documents...

- Vendor data collection tools and instructions
- Vendor administrative databases, policies and procedures
- Vendor P4P clinical data submissions
- Vendor update documents
- Data flow between vendors

Software Certification

The auditor is required to assess compliance with this standard. No item is affected by software certification.
P4P Audit Review for POs
Policies and Procedures

The P4P Audit Review

Health Plan and PO responsibilities

Any organization that produces P4P data must undergo a P4P Audit Review. Licensed organizations contracting with a health plan or PO should ensure that NCQA's requirements are met. Health plan and PO requirements and responsibilities are listed in Integrated Healthcare Association California Pay for Performance Program: P4P 2007 Measurement Year Manual.

Licensed Organization and Certified Auditor qualifications

NCQA has a licensing program for organizations interested in conducting HEDIS Audits and a certification program for individual auditors. NCQA posts lists of Licensed Organizations and Certified Auditors on its Web site under HEDIS programs.

Monitoring and Oversight of Audits

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

Program goals

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

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

Performance categories:

1. Pre-audit
   Includes audit strategy, team selection, preparation and initial assessment.

2. Information system assessment
   Includes evaluation of systems and processes used to collect and report P4P measures.

3. Measure compliance
   Includes determination of compliance with P4P technical specifications.

4. Reporting
   Includes formation about the initial audit findings and the process for finalizing rates and rendering a final audit opinion.

5. Work papers
   Includes documentation and evidence that support the audit activity and decisions in four major areas: offsite, onsite, post-onsite and overall audit effectiveness.
Monitoring results

NCQA focuses on client communication, BAT assessment, core set selection and source code review strategies (when appropriate), information systems assessment and P4P determination evaluation, documentation of issues and resolution, follow-up documentation, submission tool validation and Final Audit Reports.

Licensed Organizations receive an annual monitoring report from NCQA that identifies areas of achievement and areas for improvement. The report includes performance scores that are compared to the prior year’s performance scores and the mean performance score of all Licensed Organizations. Licensed Organizations are required to submit a corrective action plan to NCQA for all identified areas of improvement.

NCQA also monitors the quality and satisfaction of the Audit Program through a survey provided to audited health plans and POs after each reporting cycle. The health care organization rates its Licensed Organization on various aspects of the audit process, and the findings are used in ongoing evaluation of Licensed Organizations and audit standards and guidelines.

Portability of Audit Opinion

Because accountability at the measure level is crucial to maintaining audit integrity, NCQA allows an audit result on a measure rendered by one Licensed Organization to be used in another Licensed Organization’s opinion without further review.

NCQA does not allow the portability of audit opinions at the process level (i.e., IS review); therefore, one Licensed Organization’s assessment of vendor information systems is not transferable to another Licensed Organization.

Confidential communication

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

Disclaimer

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

Audit Appeal and Grievance Procedures

The Licensed Organization must maintain an appeals process acceptable to NCQA that gives organizations the opportunity to appeal an Audit Review result it has issued. The Licensed Organization’s appeal process must meet all NCQA requirements stated in HEDIS 2008 Volume 5.

Software Certification

POs and health plans that self-report clinical measures may find value in using software certified by NCQA.
If the PO or health plan uses an NCQA-certified software vendor, the auditor reviews source code for only those measures that are not certified.

If the PO does not use an NCQA-certified software vendor, the auditor must review source code for all measures. If the health plan does not use an NCQA-certified software vendor, the auditor reviews the source code for all HEDIS measures in the core set; the core set should include, or be augmented to include, measures that represent P4P reporting.

In addition, the auditor must review the source code for the distribution of services to specific providers, any variations from the HEDIS specifications (e.g., a different continuous enrollment period), the ENCRATE measure, and all non-HEDIS measures.

Software Certification does not include the testing measures. If the PO or health plan reports any of the testing measures, they have the option of including the measure in the audit process.

Software vendors are now participating in the 2007 certification testing process. A list of vendors is available on the NCQA Web site http://www.ncqa.org/Programs/HEDIS/SoftCert/index.htm. The 2008 certified software products will be available in January 2008.

### Advertising

Following completion of an audit, the PO may use the NCQA audit seal to market itself as having completed a NCQA Audit Review. (see Advertising and Marketing Section in the *P4P Integrated Healthcare Association California Pay for Performance Program: 2007 Measurement Year Manual*

### Revisions to Policies and Procedures

At its sole discretion, NCQA may amend its *Policies and Procedures, Appeal and Grievance Procedures* or any other audit program policy.
Audit Process

The P4P Audit Review process includes all parts of the HEDIS Compliance Audit that are relevant to POs reporting P4P clinical data. There are three key parts to the audit review; each is described in detail in the following sections:

**Initial offsite process…**
- Contract Execution
- BAT Assessment
- Site Visit Planning
- Manual Source Code Review

**Onsite process…**
- Site visit and follow-up documents

**Post onsite and reporting…**
- Corrective actions
- Audit results
- Data submission
- Audit Review Report
The Offsite Process

During a P4P Audit Review, many activities occur away from the PO’s location. The audit preparation phase includes all activities that occur before the site visit, such as selecting and contracting with a Licensed Organization, negotiating a timeline, completing the Provider Organization Baseline Assessment Tool (PO BAT), and planning the site visit. Other offsite activities include source code review. The following describes the activities that occur prior to the site visit:

- Contract Execution
- PO BAT Assessment
- Manual Source Code Review
- Site Visit Planning and Conference Calls

Contracting

Select an NCQA-Licensed Audit Organization

The first activity in audit preparation is contract execution. The PO selects and contracts with an NCQA-Licensed Organization to conduct the P4P Audit Review. NCQA lists Licensed Organizations on its Web site at www.ncqa.org/Programs/P4P/index.htm.

All Licensed Organizations employ or contract with Certified HEDIS Compliance Auditors. The PO should contact these organizations for audit bids. The contracting phase includes defining the scope of the audit, executing the contract with all the necessary ancillary agreements (e.g., confidentiality and conflict of interest) and negotiating a timeline.

Negotiate a timeline

During the contracting phase, the PO and the Licensed Organization negotiate an audit timeline. To guide this negotiation, NCQA suggests completion dates for several audit milestones. Although the auditor and PO may select a different timeline, all parties should be aware of the consequences for the remaining audit activities. If key milestones are missed, the PO might not have sufficient time to respond to the auditor’s requested corrective actions. As a result, PO measures could be deemed Not Reportable (NR).

<table>
<thead>
<tr>
<th>Task</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO contracts with an NCQA-Licensed Organization</td>
<td>December 30*</td>
</tr>
<tr>
<td>PO submits the completed Baseline Assessment Tool to auditors</td>
<td>January 31*</td>
</tr>
<tr>
<td>PO submits the completed source code to auditors for review</td>
<td>April 3*</td>
</tr>
<tr>
<td>Onsite visits completed</td>
<td>April 21*</td>
</tr>
<tr>
<td>PO completes all corrective action and follow-up requests and submits the data submission file to the auditor for final review</td>
<td>May 9*</td>
</tr>
<tr>
<td>Submit final auditor approved data submission file to DDD</td>
<td>May 16</td>
</tr>
<tr>
<td>Licensed Organizations submit Final Audit Reports to NCQA</td>
<td>July 15</td>
</tr>
</tbody>
</table>

* Suggested dates
Baseline Assessment Tool

The PO BAT

The Provider Organization Baseline Assessment Tool (PO BAT) is a comprehensive document auditors use to review information about the PO’s systems for collecting and processing data to produce measure reports.

The PO BAT also describes the operational and organizational structure of the PO and is used by auditors to plan the site visit. As an initial activity, the PO completes or updates the PO BAT included in this manual. (See Appendix 1: Physician Organization Baseline Assessment Tool [PO BAT]; electronic copies are available on the IHA Web site at http://www.iha.org/Ihaproj.htm.)

NCQA requires the organization to provide the auditor a completed PO BAT each year, with adequate responses to all questions. PO BATs submitted subsequent to the initial year should indicate clearly what information is new or changed, and the “Date of completion or update” at the end of each section should be filled in. It is the organization’s responsibility to provide information, and if it does not, the auditor must obtain clarification.

The organization must submit a current signed copy of “Attachment 1.1” every year. An electronic version is acceptable.

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

Timing

The PO BAT must be completed for the auditor to plan onsite activities. The auditor uses the PO BAT responses to identify areas that require further clarification, and must maintain the completed PO BAT and all supplements received during the audit as part of the working papers.

Manual Source Code Review

Manual source code review is the process of examining original programming to verify that the program is accurate and complete. Source code for measures is requested in advance so that the audit team can review it before the onsite visit. The Certified Auditors in charge of code review should be proficient in programming languages, knowledgeable about the PO’s systems and familiar with P4P clinical specifications and guidelines.

The audit team is responsible for reviewing and confirming the accuracy of source code for all calculations (denominator, numerator and algorithms) for each measure reviewed. For each measure, the following processes may be reviewed (examples of what information is reviewed are also included):

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

Source code process

To ensure that the reviewer can perform a thorough assessment of source code, the PO must provide flowcharts; software documents that explain the programming logic and design; input and output file record layouts and field descriptions; input and output record counts and run logs.

The source code review process can be completed in one of two ways:

• The Certified Auditor analyzes the code independently before or after the onsite review and communicates perceived discrepancies to PO staff.
• During the onsite visit, the auditor examines source code with PO staff.

The first approach saves time, but may result in more questions if the reviewer does not fully understand the PO’s systems. The joint review may be more efficient if it can be completed during the onsite visit.

One advantage of onsite code review is that it allows the reviewer to determine quickly and easily if certain tests have not been performed. Verifying that the code properly checks for continuous enrollment may be difficult, but it is easy to ascertain if it tests the proper age range or performs a required gender test. Similarly, exclusions based on clinical codes can be readily determined.

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 partly or completely bypassed. The auditor must check that the program ran as specified.

One way to test the code is to rerun it against the original files, which requires a file freeze of the P4P clinical data repository. Another test is to run the code against a test file prepared by the auditor in the format of the expected input file.
If the subset is small, the auditor can select a subset of the total file (before the denominator extract) and hand-check the results. An alternative is to prepare a set of data (a test deck) with known results, modify the PO’s program to read it and compare program results to expected results.

**Decision Point Grid**

The auditor completes a Decision Point Grid (see Appendix 3: Auditor’s Decision Point Grid) for each measure to document that measure elements have been checked and verified.

**Review results**

The source code review can have one of three results:

- Agreement that the code produces the intended and appropriate output
- Questions about aspects of the code that require programmer review and possible job reruns
- Determination that the code is inadequate and must be rewritten before the results can be accepted

### Planning the Onsite Visit

**Onsite audit team**

After the initial PO BAT review, the auditor forms the onsite audit team. The Certified Auditor selects team members based on the unique characteristics of the entity being audited. The team will consist of a minimum of one Certified Auditor (CHCA), with additional auditors as necessary to meet the required mix of skills.

- P4P knowledge
- Data modeling skills
- Claims experience
- Information systems experience
- Programming experience
- Interviewing skills
- Merger/acquisitions knowledge
- Data warehousing experience

The lead auditor may structure the team based on the number and type of locations that require site visits. NCQA recommends one to two individuals for the onsite visit, with the Certified Auditor serving as the team leader; however, a minimum of one Certified Auditor is required per PO site visited.

**Offsite conference call**

After the onsite visit and audit team are organized, the lead auditor conducts a conference call to finalize the P4P-relevant locations for audit onsite visits, identifies offsite issues and makes offsite requests. If the PO’s source code is complete at this time, the audit team may ask the PO to submit the source code and supporting documentation for the core set measures.

About two weeks before the onsite visit, the team has a conference call with the PO to review the onsite agenda, resolve issues and ensure availability of requested documentation and staff. For a single location PO, 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 PO.
**Sample Onsite Agenda**

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00–10:15 a.m.</td>
<td><strong>Introductions and Overview of Audit Process</strong>&lt;br&gt;• Review objectives and agenda&lt;br&gt;• Review audit process</td>
</tr>
<tr>
<td>10:15–10:30</td>
<td><strong>Overview of Physician Organization</strong>&lt;br&gt;• Management structure&lt;br&gt;• Contracting arrangements</td>
</tr>
<tr>
<td>10:30–11:00</td>
<td><strong>Overview of P4P Reporting Process</strong>&lt;br&gt;• Timeline, staff responsibilities&lt;br&gt;• Measures and methods of calculation&lt;br&gt;• Data sources</td>
</tr>
<tr>
<td>11:00–12:00 p.m.</td>
<td><strong>Claims/Encounter Data System and Processes</strong>&lt;br&gt;• Policies and procedures&lt;br&gt;• Forms and coding&lt;br&gt;• Data entry&lt;br&gt;• Data flow&lt;br&gt;• Claims/encounter processing system walkthrough</td>
</tr>
<tr>
<td>12:00–12:30</td>
<td><strong>Data Completeness</strong>&lt;br&gt;• Factors that impact data completeness&lt;br&gt;• Methods for estimating data completeness</td>
</tr>
<tr>
<td>12:30–1:00 p.m.</td>
<td><strong>Lunch</strong></td>
</tr>
<tr>
<td>1:00–1:30</td>
<td><strong>Eligibility/Membership Data System and Process</strong>&lt;br&gt;• Overview of eligibility/membership processing and procedures&lt;br&gt;• Membership system walkthrough</td>
</tr>
<tr>
<td>1:30–2:30</td>
<td><strong>Information Systems/Decision Support Systems</strong>&lt;br&gt;• Data warehousing/creation of P4P data repository&lt;br&gt;• Development of source code&lt;br&gt;• Incorporating ancillary and vendor data&lt;br&gt;• Data control/security procedures</td>
</tr>
<tr>
<td>2:30–4:15</td>
<td><strong>Detailed Measure Review</strong></td>
</tr>
<tr>
<td>4:30…</td>
<td><strong>Conclusion</strong>&lt;br&gt;• Present findings from site visit</td>
</tr>
</tbody>
</table>
The Onsite Process

Opening Meeting

The opening meeting introduces the audit team to the PO staff in charge of P4P development and reporting, and gives the PO an opportunity to present an overview of the entire P4P data collection process.

The members of the audit team explain how they conduct a P4P Audit Review. They reiterate the audit’s purpose, the scope of the work, the required documentation, the interviews and tests they will perform and how audit results are assigned to each measure. Before the end of the meeting, interviews may be scheduled and, based on the review of the PO BAT, the NCQA Certified Compliance Auditors either receive or request additional information.

Onsite Audit Methodologies

The Certified Auditor assesses the ability of the PO systems and processes to produce reliable P4P results, and the extent to which the PO staff has accurately interpreted the P4P clinical 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.

Interviewing

Throughout the onsite visit, the Certified Auditor and audit team members interview PO staff to gain insight into the accuracy and reliability of the reported P4P 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 PO BAT and obtains more detail by interviewing staff members who are familiar with the PO’s information systems and involved in the P4P data collection process. The auditor records the name and title of everyone interviewed.

<table>
<thead>
<tr>
<th>Examples of Discussion Topics and Recommended PO Personnel to Be Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>P4P team leader</td>
</tr>
<tr>
<td>• Overall data collection and reporting</td>
</tr>
<tr>
<td>• Results: The PO’s impression and rationale</td>
</tr>
<tr>
<td>Quality improvement director</td>
</tr>
<tr>
<td>• Use of P4P information</td>
</tr>
<tr>
<td>• Underlying data issues</td>
</tr>
<tr>
<td>Information systems (services)</td>
</tr>
<tr>
<td>All systems and databases supporting P4P reporting</td>
</tr>
<tr>
<td>Operations management director</td>
</tr>
<tr>
<td>Claims/encounter processing</td>
</tr>
</tbody>
</table>

Interview questions

Interviews are tailored to the PO’s P4P data production environment and issues raised by the PO BAT.

- What coding methods are used and what degree of specificity is maintained? *(IS 1)*
- Is proprietary coding used? If so, how is it mapped to standard codes? *(IS 1)*
- On what forms are the clinical data captured, and what formats are used for the delivery vehicle? *(IS 2–IS 3)*
• How are data delivered to the PO, and what are the proportions, by delivery type (electronic, mail, courier, fax)? *(IS 2–IS 3)*

• How are data manipulated to produce the P4P repository from the entry/transaction files? *(IS 4)*

• What are the procedures for file and system back-up, access security, power protection, system upgrade and system modification? *(IS 5)*

**Primary source verification**

This task confirms the validity of the source data described in the PO BAT. The auditor examines all paper forms and other input media (e.g., claims/encounters, practitioner credentialing documents, EDI protocols) used to produce P4P measures.

The review verifies that the information from the primary source matches the output information used for P4P reporting. The review addresses content and format and traces the movement of data from the originating source to the P4P clinical repository to assess accuracy and completeness. This process is especially appropriate for electronic transmission of primary source data.

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

**Forms and data to review**

Examples of forms (including electronic submissions or EDI) that typically contain P4P-relevant data and which should be reviewed include the following.

• Practitioner claims/ encounters

• Prescription data

• Registry or other Supplemental data

• Claims log (receipt and mailed payment tracking)

• Lab result forms or files

**Process review**

The PO should have documentation describing the processes that apply to each IS standard: collecting, storing and reporting data. The auditor reviews the documents and explores methods used by the PO to ensure that policies and procedures are followed, focusing on the integrity and completeness of the data required for P4P. Documentation describing incentives to perform procedures properly is critical.

• 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 non-compliance. *(IS 3)*

• Training and procedure manuals for claims/encounter data-entry staff. Documentation should describe objectives, methods and processes involved, how performance is monitored and measured and how proper execution is rewarded. *(IS 2–IS 3)*
• Manuals for application system development methods, database development and design and decision support system use. *(IS 4, IS 5)*

• Procedures for monitoring hardware function, capacity, physical state and access. *(IS 5)*

• Log forms for all hardware activities, including backup, failure response and recovery and system optimization techniques that clearly describe the data required and do not allow routine execution. *(IS 5)*

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

The auditor must review and understand data and systems-oriented documents. NCOA requires the auditor to review P4P relevant systems and processes during an onsite visit. Examples of systems or programs that might be reviewed include:

• 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 *(IS 2–IS 4)*

• Documentation for data receipt, entry, transfer and manipulation showing how the programs interact with the operations; if documentation is explicit about user options and program paths *(IS 2–IS 4)*

• Flow charts describing the data flow and the systems involved

• Descriptive documents of third-party code; date of receipt, especially procedure, diagnostic, revenue and other codes *(IS 1, IS 2)*

• Control system documentation, including logs, flow charts and codes for backups, recovery, archiving and other control functions *(IS 5)*

• Documentation of system upgrades and changes, including:
  • Project plans
  • Project milestones
  • Impact studies
  • Test plans
  • Test activity
  • Results
  • Sign-offs *(IS 1–IS 5)*

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

The auditor observes a process to ascertain the reliability and accuracy of reported information and whether procedures are followed. Observation may assess data entry or other data manipulation. Operations that might be observed include the following.

- Data entry of claims/encounters. The auditor should confirm that all fields described as mandatory are entered with complete coding. *(IS 1–IS 3)*
- Claims operations that may have overrides and exceptions and which require explanations if they occur. *(IS 2)*
- Computer operations and system security plans to confirm that prescribed procedures are followed. *(IS 4, IS 5)*

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.

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. The auditor may ask a claims processor to perform the following tasks.

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

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

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

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 P4P measures 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 the 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 and membership changes
- Intermediate files created by extracts, queries and analysis applications
- P4P repository files (i.e., input to P4P-measure computation programs)
- Denominator files for P4P measures
- Sample files randomly selected from denominator files
- Numerator files based on administrative data
The first three file types above are related to the IS standards because they are associated with preserving the integrity of the data in the P4P repository; the last three pertain to the HD standards. The auditor confirms the integrity of files for all categories. The methods vary, depending on file type, potential for corruption, complexity of the programs that build and update the file and file access capability. By examining file layouts, the auditor determines if certain fields may be missing, such as:

- Multiple practitioner locations
- Number of prior membership segments
- Prior membership IDs

File content examination methods include:

- Request transaction file output and compare to a sample set (e.g., 20 or 30 records) of source documents. The auditor compares the data entry result to the content of the entry documents and checks for completeness, accuracy and format. (IS 1–IS 3)

- 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 for a source document to transaction file comparison. (IS 1–IS 3)

- 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. (IS 4)

- 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., membership data by age and sex).

- Review third-party data.

- Examine documentation that describes how the measure (or part of the measure) is collected, if calculated by the vendor.

- Identify how members are tracked from vendor classifications to PO classifications.

- Verify codes used to identify members who meet the P4P 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 PO BAT Data Completeness sections and identify possible areas of concern. During the onsite component of the audit, the auditor should assess the PO’s claims lag and encounter data submission rates, along with studies on data completeness that the PO may have performed. Data completeness issues must be quantified, and any Not Report must be supported by a determination of material bias.

NCQA provides the Certified Auditor with commercial HEDIS rate means and percentiles, and will also provide them with results from the 2003 measurement year/2004 P4P reporting year. The auditor may use the rate means and percentiles and other available information to conduct reasonability assessments of the initial and final results calculated by the PO. 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.

To help the auditor assess data completeness, NCQA provides enrollment ratios of eligible members to commercial enrollment. As with the HEDIS means and percentiles, a Not Report should not be assigned to a measure whose enrollment ratio is significantly above or below the mean enrollment ratio. Further investigation of the measure must be conducted to determine if data completeness issues affect the PO’s P4P clinical measure rate.

Closing Conference

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

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

- A list of unresolved questions and deficiencies found in the PO BAT or during the visit, with corrective actions and their completion 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.
The Post-Onsite and Reporting Process

The nature of the post-onsite work depends on the outcome of the onsite visit. Typically, while onsite, the Certified Auditor typically finds issues that the PO must resolve before the Final Audit Report is issued. The auditor reviews and reaudits the corrective actions and determines if they justify a change in the initial findings or audit results. The audit team sends the audit results to the PO and NCQA in the reporting phase of an NCQA P4P Audit Review.

Corrective Actions and Reassessment

**Improving accuracy and reliability**

The post-onsite phase may be an iterative process in which the PO responds to requests and the auditor incorporates the PO’s documented comments and corrective actions, as appropriate. After the last review of material forwarded by the PO, the auditor approves the final rates and results and produced the Final Audit Report. For some measures initially assessed NR, the PO can follow the auditor’s recommendations to improve the accuracy and reliability of the reported rate. The auditor reviews the documents showing that the PO made the improvements and that the P4P measure rate accurately reflects performance. Corrective actions the auditor may suggest include the following.

- 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 PO and the auditor agree on a completion date for corrective actions, usually no less than two weeks before data file submission. On or before the completion date, the PO must give the results, supporting documentation and comments to the auditor, who determines whether modification is necessary. If the PO declines to revise a noncompliant methodology, the auditor assesses if noncompliance affects reporting and designates the NR measures. This information and the recommendations are included in the Final Audit Report. If the PO does not take corrective action and noncompliance does not significantly bias accuracy or comparability, this is noted and included in the Final Audit Report.

**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 P4P determinations.
  - Undocumented verbal communication or statements made by the PO are insufficient to complete the assessment.
- The revised programming logic used in measurement computation.
- The primary data source, such as claims or encounter forms, or summarized claim detail. The auditor may also review other primary data sources that affect the PO’s data and algorithmic integrity.

**Note:** To meet the P4P data submission deadline, all follow-up activities and corrective actions must be completed two weeks before the data file submission to DDD.
Audit Results

P4P Audit Reviews result in audited rates or calculations at the measure level and indicate if the measures can be publicly reported. All measures selected for reporting must have a final, audited result. A measure selected for reporting by a PO can receive a rate of NR if the auditor determines it is not reportable.

The auditor approves the rate or report status of each measure as shown in the following tables.

<table>
<thead>
<tr>
<th>Rate/Result</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–XXX</td>
<td>Reportable measure</td>
<td>Rate or numeric result for P4P measures</td>
</tr>
<tr>
<td>LD</td>
<td>Low Denominator</td>
<td>The self-reported denominator is &lt;30</td>
</tr>
<tr>
<td>NB</td>
<td>No Benefit</td>
<td>The members' health plan did not offer the health benefit required by the measure (e.g., pharmacy)</td>
</tr>
<tr>
<td>NR</td>
<td>Not Reportable</td>
<td>The measure was calculated, but the rate was materially biased</td>
</tr>
<tr>
<td>NC</td>
<td>Not Collected</td>
<td>The reporting entity did not report the measure</td>
</tr>
</tbody>
</table>

Note: For measures reported as a rate, materially biased is any error that causes a (+/-) 5 percentage point difference in the reported rate.

Note: Transition and testing measures will not receive an audit result. These measures are collected in 2008, but not audited.

P4P Data Submission

Final Audit Opinion

At the close of the audit, the auditor renders the Final Audit Opinion, which contains an Audit Review Statement. The Final Audit Opinion must be submitted to NCQA 30 days after the P4P reporting deadline. The auditor submits this report to the audit coordinator at NCQA.

Data submission file (rates and results)

NCQA will register all P4P POs in December to determine their intent to self-report clinical measures, and will provide information on data submission responsibilities to all self-reporting groups. In January, NCQA’s subcontractor, Diversified Data Design Corp. (DDD), will provide POs with a standard file format for submitting data. The PO’s data submission file includes numerators, denominators, rates, and audit results.

In May, the auditor signs off on the PO’s data submission file to DDD, which includes all data elements defined in the data submission file.

Final date for submission


P4P PO Audit Review Statement

The template for the P4P PO Audit Review Statement follows. The auditor must submit this document electronically to the audit coordinator at NCQA.
P4P PO Audit Review Statement

We have examined the 2008 submitted measures of [PO name] for conformity with the MY 2007 P4P Manual. Our audit planning and testing was constructed to measure conformance to the MY 2007 P4P Manual for all measures presented at the time of our audit.

This report is the [PO name] management’s responsibility. Our responsibility is to express an opinion on the report based on our examination. Our examination included procedures to obtain reasonable assurance that the submitted 2007 Performance Report presents fairly, in all material respects, the PO’s performance with respect to the P4P MY 2007 Physician Organization Manual. Our examination was made according to P4P Manual, and accordingly included procedures we considered necessary to obtain a reasonable basis for rendering our opinion. Our opinion does not constitute a warranty or any other form of assurance as to the nature or quality of the health services provided by or arranged by the PO.

In our opinion, the 2008 submitted measures of [PO name] was prepared according to the MY 2007 Physician Organization Manual and presents fairly, in all material respects, the PO’s performance with respect to these specifications.

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

________________________________________ ____________________________
(NCQA-Certified HEDIS Audit Reviewer) (Date)

________________________________________ ____________________________
(Responsible Officer) (Date)

Organization ID: ________________________________
Submission ID(s): _______________________________

Final Audit Report

Contents

When the audit is complete, the auditor prepares a Final Audit Report that includes the Summary Report and the IS Assessment findings.

Within 30 days after the P4P reporting deadline, the auditor must submit copies of the report to the PO and to NCQA, which uses it to evaluate the audit process and ensure that all audits are conducted according to guidelines. The report must provide enough information for NCQA to evaluate and conclude that the auditor’s results are supported.

The Final Audit Report must include:

- 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

• PO information
  • PO names and addresses
  • Organization and submission IDs
  • Name, position and address of the individual at the PO responsible for P4P reporting (i.e., sign-off authority)
  • Locations of P4P report preparation activity, with contact name and address for each location
  • Certified software vendor’s name and the Software Certification Report, if applicable

• Audit information:
  • Scope of the audit indicating the measures reported
  • Summary of offsite activities, including auditor strategy and considerations
    • Supplemental database findings
      – Databases reviewed and results
    • Source code review findings
      – Vendor used, if applicable
      – Source code review results
  • Results and rationales for the P4P measures
  • A summary of the auditor’s findings from the Describe Impact on P4P Reporting Capability column in Appendix 4: IS Standards Compliance Tool (the auditor must assess PO performance on each IS standard)

• Final Audit Opinion, comprising:
  • Audit Statement
  • Audit results and associated rates

Other Reporting Requirements

Work papers

In addition to the Final Audit Report submitted to NCQA, the Certified Auditor must retain additional working papers that are available on request for monitoring purposes. The NCQA monitoring program includes a review of these papers and ensures adherence to program policies and procedures. NCQA recommends that organizations and Licensed Organizations retain P4P audit review documentation for three years.

Work papers include all relevant documentation completed, requested or reviewed during the P4P audit review.

General Information

• Current PO and Licensed Organization information:
  – Organization name, address, primary contact, additional audit participants names and titles
  – Audit team members, titles, skills and audit responsibilities, auditing and consulting history or relationship between the Licensed Organization and the PO or any PO affiliates for the past three years (e.g., IS consulting, or HEDIS consulting, HEDIS or information systems
• Copies of all current audit contracts or letters of intent (with price expunged)

• Copies of all current Attestations, including:
  – IS auditing, financial auditing, financial advising, auditing, partnerships, stock ownership, participation in board-of-director activities
  – Relationship between the Licensed Organization and any other group hired by the organization to participate in the audit; for example, the organization’s software vendor

• An audit timeline that includes negotiated and actual dates for at least:
  – Opening meetings or conference calls
  – Receipt of PO BAT
  – Offsite data requests and subsequent deliveries
  – Onsite visits for each location
  – Offsite activities such as source code review, document review, conference calls
  – Follow-up documentation to the PO
  – PO responses
  – DDD submissions by the PO to the Licensed Organization
  – Final DDD submissions

• Audit correspondence (e-mail):
  – Key correspondence among team members
  – Key correspondence between auditors and the PO

Offsite Activity Files

• The PO BAT papers:
  – The PO BAT as executed by the organization and certified software vendor, if applicable
  – A paper or electronic copy of Attachment 1.1 with the appropriate signature and date
  – Auditor notes from reviewing the PO BAT, including all preliminary issues and items to discuss before or during the onsite visit
  – All requested documents
  – All documents received from the PO (before the onsite visit) and auditor’s notes and analysis for each, including if the issue is resolved or under discussion

• Source code review:
  – If the PO does not use 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
    • Denominator identification, including separate review of systems for determining continuous enrollment and member-month calculations sampling algorithms
    • MRR entry and transfer programs
    • Numerator algorithms
  – Core set selection documents including rationales and results
  – A completed Auditor’s Decision Point Grid for each measure with reference to applicable HD standards and comments on the compliance with each standard
  – For plans with certified software, an Auditor’s Decision Point Grid 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:
  - Databases reviewed, including the policies, procedures, data files, reviewed sample, and results

- Interim versions of the IS standards compliance tool

- Audit correspondence (e-mail):
  - Key correspondence among team members
  - Key correspondence between auditors and the PO

### Onsite Activities

- A complete record of onsite activities, including agenda, participants, and supplements to the PO BAT

- 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)

### Audit Result Files

- Standard compliance tools:
  - A Final IS Standards Compliance Tool, with auditor’s notes on the adequacy of data collection, storage and manipulation of key files to produce accurate measures, including issues and possible problem areas and comments on compliance with each standard as it affects P4P reporting; and sufficient evidence to support audit results for all measures
  - Preliminary rate submission tool with review notes, including this year/last year comparison, benchmark comparison, auditor’s notes, questions and requests for additional information
  - The PO’s response to preliminary submission tool issues and rates
  - Final locked DDD submission
  - Final Audit Report

- Audit correspondence (e-mail):
  - Key correspondence among team members
  - Key correspondence between auditors and the PO
Appendix 1

Physician Organization Baseline Assessment Tool (PO BAT) for Self-Reporting POs Measurement Year 2007

Released November 2007
APPENDIX 1

PHYSICIAN ORGANIZATION BASELINE ASSESSMENT TOOL (PO BAT)

Introduction

Welcome to NCQA’s Baseline Assessment Tool (BAT) for physician organizations (PO). The PO BAT is an integral part of the P4P Audit Review. The PO BAT collects information about the effect of your PO’s data management practices on P4P clinical measure reporting. It is not intended to evaluate the effectiveness of your information systems.

Changes to the PO BAT

- Added clarifications for Supplemental Databases throughout, and additional document requests in BAT Sections 2 and 2.1.
- Added Requested Documentation Label 7.4: Source code development assignments.
- Effective May 23, 2007, UB-04 replaced UB-92. All references were updated to include this change.

Measurement Year Versus Baseline Questions

The flow of the BAT facilitates completion by PO staff and vendors. Questions are grouped into categories that represent the different types of data and processes required to collect P4P clinical measures. In addition, for the claim/encounter and membership data processing sections, questions were divided into two categories, described below.

- **Measurement year** questions request information on how data were processed during the measurement year (e.g., timeliness and accuracy of processing, vendor (e.g. lab) relationships, system upgrades/conversions, forms and codes used). Current answers for measurement year questions are required annually for each PO or vendor data processing system. For P4P 2008 reporting, the measurement year is 2007.

- **Baseline questions** request information about data systems and processing policies (e.g., system data elements, data processing procedures). Completion of baseline questions is required the first year for each PO and vendor data processing system and thereafter if processes or systems change, if a new audit firm is used or if the audit firm requests them. Baseline questions are in:
  - Attachment 2.1: Claims/Encounter Baseline Questions

While initial completion of the BAT might require significant time, completion in subsequent years of the P4P program will be simplified, since in most cases you will not be required to resubmit the baseline question attachments.

Completing the BAT

Completing the BAT is a required component of the P4P Audit Review process. The answers and tables in the BAT provide auditors with the preliminary information they need to conduct the audit. All information requested in the BAT is essential to the audit process, and auditors will ensure that each question relevant to your organization is answered accurately and completely. Auditors will help you determine whether if all of the questions included in the BAT are relevant to your provider organization. Keep in mind:

- A separate BAT must be completed for each PO that participates in the P4P Audit Review process (e.g., if you are reporting for several POs, a separate BAT must be completed for each).
• The PO must complete a new BAT or update a previous one; the auditor may not prepare it for the PO.
• Answers are only for the population under review (e.g., commercial HMO/POS).
• All questions relate to the measurement year systems and processes, unless otherwise indicated.
  For P4P 2008 reporting, the measurement year is 2007.
• Claim/encounter individual sections and attachments should be completed for each PO (e.g., MSO) data processing system.

Work with your auditor to ensure accurate completion of the BAT. To help link the information provided in the BAT to individual P4P Audit Review standards, each section lists the standards it addresses. POs are encouraged to refer to the relevant standards as they prepare the BAT.

**Requested Documentation**

At the end of each section, you are asked to attach workflow diagrams, reports and other documents. Label all documents as indicated in the Requested Documentation tables. If you are unable to provide the requested documentation when you submit the BAT, indicate it in the Requested Documentation table and tell your auditor when you will provide the documentation.

If when responding to BAT questions you determine that a separate document might provide a more complete or accurate response, feel free to include it as an attachment. You may also want to include documents previously requested by your auditor. Add the attachment name, description and label to the applicable Requested Documentation table.

Remember that you are not limited to providing the documentation requested; you are encouraged to provide additional information that helps clarify an answer or which eliminates the need for a lengthy response.

**Successfully Completing the BAT**

POs that give clear and complete responses have more efficient onsite visits and receive fewer requests for follow-up documentation. As you complete the BAT, keep the following in mind.

• Distribute a copy of the BAT instructions to all individuals involved in completing the BAT
• Ensure that all individuals completing the BAT answer for the commercial HMO/POS population only
• Provide electronic copies of completed BAT sections and attachments wherever possible
• Clearly label all electronic documents, indicating section or attachment number and description
• Accurately label all attachments and add additional attachments to the applicable Requested Documentation table

Auditors hold the BAT and attached documents in strict confidence; however, NCQA uses the BAT and attached documents to assess auditor performance.
Appendix 1—PO Baseline Assessment Tool: Section 1

Section 1: General Information

This section gathers general information about your PO. Answer all questions completely.

PO name:

1. In what year was the PO established?

2. Have there been any mergers/acquisitions in the past three years?

3. In Table 1.1, provide contact information for your PO’s primary and secondary contacts for the P4P Audit Review:

Table 1.1: Contact Information

<table>
<thead>
<tr>
<th>Primary Audit Contact</th>
<th>Secondary Audit Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Company</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City, state, zip</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td>E-mail address</td>
<td></td>
</tr>
</tbody>
</table>

4. In Table 1.2, provide information about the product line/product under review for the measurement year.

Table 1.2: Product Line Information

<table>
<thead>
<tr>
<th>Product Line: Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product: HMO/POS</td>
</tr>
<tr>
<td>Year of First P4P Clinical Report</td>
</tr>
<tr>
<td>Year of First P4P Audit Review</td>
</tr>
</tbody>
</table>

Prior year's submission*

- Org ID
- Submission ID

* Complete if you reported in the prior year and the rates were submitted to DDD.

5. In Table 1.3, for the product line/product under review, indicate one of the following for each measure:

- **A** Measure reported using administrative (i.e., claims and encounter) data.
- **NB** The members’ health plan did not offer the health benefit required by the measure (e.g., pharmacy)
- **NC** The reporting entity did not report the measure.
### Table 1.3: Measurement Year P4P Clinical Report

<table>
<thead>
<tr>
<th>Product Line: Commercial Product: HMO/POS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>ENR</td>
</tr>
<tr>
<td>CIS</td>
</tr>
<tr>
<td>URI</td>
</tr>
<tr>
<td>BCS</td>
</tr>
<tr>
<td>CCS</td>
</tr>
<tr>
<td>CHL</td>
</tr>
<tr>
<td>CMC</td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>CDC</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>ASM</td>
</tr>
<tr>
<td>COL</td>
</tr>
</tbody>
</table>

**Transition Measures, Optional for Reporting:**

<table>
<thead>
<tr>
<th>Measure</th>
<th>A, NB or NC?</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>CWP</td>
<td>Appropriate Testing for Children With Pharyngitis</td>
<td></td>
</tr>
<tr>
<td>AAB</td>
<td>Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis</td>
<td></td>
</tr>
<tr>
<td>LBP</td>
<td>Use of Imaging Studies for Low Back Pain</td>
<td></td>
</tr>
<tr>
<td>MPM</td>
<td>Annual Monitoring for Patients on Persistent Medications</td>
<td></td>
</tr>
<tr>
<td>CDC</td>
<td>Diabetes Care - HbA1c Good Control</td>
<td></td>
</tr>
<tr>
<td>PAH</td>
<td>Potentially Avoidable Hospitalizations*</td>
<td></td>
</tr>
</tbody>
</table>

**Testing Measures, Optional for Reporting:**

<table>
<thead>
<tr>
<th>Measure</th>
<th>A, NB or NC?</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRN</td>
<td>Inpatient Readmission Within 30 days*</td>
<td></td>
</tr>
<tr>
<td>DHR</td>
<td>Depression Screening and Assessment for High-Risk Patients*</td>
<td></td>
</tr>
<tr>
<td>AMR</td>
<td>Asthma Medication Ratio*</td>
<td></td>
</tr>
<tr>
<td>ECS</td>
<td>Evidence-Based Cervical Cancer Screening of Average-Risk, Asymptomatic Women*</td>
<td></td>
</tr>
</tbody>
</table>

* Indicates that there is a difference between what is being reported for P4P MY2007 and what is being reported by MCOs for HEDIS.

M Indicates the P4P MY 2007 measures being collected and publicly reported for Medicare Advantage. No payment will be awarded for these measures.

N Indicates that the measure is a non-HEDIS measure.

6. Describe quality improvement activities in place during the measurement year that might affect P4P rates.
### Requested Documentation

The documentation requested in this section is summarized in the table below. Label all documentation as described in the table.

<table>
<thead>
<tr>
<th>Document</th>
<th>Details</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attestation</td>
<td>The staff member responsible for ensuring the completeness and accuracy of this BAT should complete the attached Attestation.</td>
<td>1.1</td>
</tr>
<tr>
<td>BAT Completion Table</td>
<td>Complete the attached table indicating which BAT sections were completed and by whom.</td>
<td>1.2</td>
</tr>
</tbody>
</table>
Attachment 1.1

Attestation

PO name:

I declare that the information provided on this Baseline Assessment Tool is, to the best of my knowledge, accurate and complete.

__________________________________________  __________________________
Signature                                      Date

__________________________________________  __________________________
Name (print or type)                           Title
**Attachment 1.2**

**BAT Completion Table**

**PO name:**

Complete the table below for each section/attachment of the PO BAT.

For sections where more than one version is completed, list each version. Keep in mind that Medical Data: Claim/Encounter Processing and Membership Data Processing—a separate section should be completed for each PO and vendor (e.g., MSO) data processing system.

<table>
<thead>
<tr>
<th>BAT Section or Attachment</th>
<th>Name of Person/Vendor Completing Section</th>
<th>Location and/or Name of Data Processing System</th>
<th>File Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1: General Information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 2: Medical Data: Claim/Encounter Data Processing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attachment 2.1: Claim/Encounter Baseline Questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 3: Medical Data: Completeness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 4: Membership Data Processing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 5: Data Integration for P4P Clinical Reporting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 6: Report Production and Control Procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 7: Vendor Oversight</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 2: Medical Data Processing
(IS 1, IS 2.1–IS 2.3)

This section requests information on the claim/encounter and supplemental data systems and processes used during the measurement year. Complete this section annually for each vendor claim/encounter data processing system and each supplemental database. For a definition of supplemental databases see General “Guideline 23” in the P4P Measurement Year 2007 Manual. A claim/encounter processing vendor includes any external entity with which the PO has contracted to perform the following tasks:

- Provide a particular type of covered service (e.g., lab, radiology, vision service), or
- Perform claim/encounter data processing functions. Vendors may include, but are not limited to, ancillary providers, provider specialty groups and intermediary organizations (e.g., MSOs).

Complete a separate Section 2 for each vendor claim/encounter data processing system. Keep in mind:

- All questions relate to the systems and processes used during the measurement year, unless otherwise indicated.
- A claim refers to a submission for the purpose of reimbursement (e.g., from fee-for-service providers) and an encounter refers to a submission that is not linked to payment (e.g., from capitated providers). Both terms refer to documentation that a medical service was provided.

### Baseline Determination Questions

**PO name:**

Complete Attachment 2.1 once for each claim/encounter or supplemental data processing system, and thereafter if the processes or systems change, if a new audit firm is used or if the audit firm requests it. For supplemental databases, complete all questions that apply to the data base policies, procedures, and data type.

### Medical Data Measurement Year Questions

**General Information**

1. In Table 2.1, provide information about the claim/encounter or supplemental data processing system described in this section.

#### Table 2.1: Medical Data Processing System

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of claim/encounter or supplemental data system</td>
<td></td>
</tr>
<tr>
<td>Type of data processed</td>
<td></td>
</tr>
<tr>
<td>Location (city, state)</td>
<td></td>
</tr>
<tr>
<td>Average monthly volume:*</td>
<td></td>
</tr>
<tr>
<td>Percentage of claims/encounters or supplemental data submitted:*</td>
<td></td>
</tr>
<tr>
<td>• On paper</td>
<td></td>
</tr>
<tr>
<td>• Electronically</td>
<td></td>
</tr>
</tbody>
</table>

*During the measurement year, for the PO under review.
2. Regarding claim/encounter or supplemental data policies in place during the measurement year:
   a. What was the time limit for when a practitioner could submit a claim/encounter or supplemental data?
   b. How was a claim/encounter or supplemental data handled if it was submitted past the deadline?
   c. Were changes implemented during the measurement year to improve your claim/encounter or supplemental data quality, processing or system? If so, describe.

### Coding Schemes

3. In Table 2.2, indicate the type of coding schemes used during the measurement year. Be sure to consider all nonstandard coding methods, including state-specific codes, internally developed codes and case or per diem rate codes. Indicate with an “X” which coding schemes your PO uses.

<table>
<thead>
<tr>
<th>Coding Scheme</th>
<th>Type of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient Diagnosis</td>
</tr>
<tr>
<td>Standard HEDIS Codes: (e.g., ICD-9, CPT, HCPCS, Revenue, DRG, NDC, CDT, LOINC, HCPCS)</td>
<td></td>
</tr>
<tr>
<td>Nonstandard HEDIS Codes:</td>
<td></td>
</tr>
<tr>
<td>• State-specific (e.g., Medicaid, state DRGs)</td>
<td></td>
</tr>
<tr>
<td>• Internally Developed</td>
<td></td>
</tr>
<tr>
<td>• Case or per Diem Rate Codes</td>
<td></td>
</tr>
</tbody>
</table>

4. If nonstandard codes were used for any of the service types outlined in the table above during the measurement year, answer the following questions.
   a. What percentage of claims/encounters or supplemental data was affected?
   b. For what services were the codes used?
   c. Were the codes received on claim/encounter or supplemental data forms from providers, or generated by the claim/encounter or supplemental data system or processors?
   d. How were the codes processed in the claim/encounter or supplemental data system? Describe.
   e. If standard codes are grouped to nonstandard codes, were the original codes maintained in the claim/encounter or supplemental data processing system?

5. If global billing codes were used during the measurement year, answer the following questions. For each service type in which global billing codes were used during the measurement year:
   a. What percentage of claims/encounters or supplemental data was affected?
   b. For what services were the global billing codes used?
   c. For codes that cover a period of treatment, what date was used on the claim/encounter or supplemental data?
Medical Data Submission Forms

6. If nonstandard, state-specific or encounter forms (i.e., other than UB-92 or HCFA/CMS 1500) were used during the measurement year, answer the following questions. For each service type in which nonstandard, state-specific or encounter forms were used during the measurement year:
   a. What percentage of claims/encounters or supplemental data was affected?
   b. For what services were nonstandard forms used?

Medical Data Processing

7. Regarding timeliness of claim/encounter or supplemental data processing during the measurement year:
   a. What were your time-to-process standards for claim/encounter or supplemental data data?
   b. What was your actual average time-to-process for claim/encounter or supplemental data data?
   c. Was there ever a backlog or delay in processing of claim/encounter or supplemental data data? If so, describe.

8. Regarding the accuracy of claim/encounter or supplemental data processing during the measurement year:
   a. Were audits of claim/encounter or supplemental data processing conducted? If so, describe what was audited and how often.
   b. What were your findings for the measurement year?
   c. Were deficiencies detected? If so, describe.

System Upgrades/Conversions

If during the past three years major changes, upgrades or consolidations were implemented in the claim/encounter or supplemental data system, answer the following questions.

9. What claim/encounter or supplemental data systems were affected?

10. What were the dates of project initiation and completion?

11. Regarding conversion of data:
   a. What claims/encounters or supplemental data were converted to the new system (e.g., all claims/encounters, or claims/encounters as of a certain date of service or date of receipt)?
   b. What claims/encounters or supplemental data were not converted to the new system?
   c. What data elements were converted to the new system?
   d. What data elements were not converted to the new system?

12. Describe the data mapping that occurred to convert data from the previous to the new claim/encounter or supplemental data system.

13. How was accuracy and completeness of data ensured in the new system?
Requested Documentation

The documentation requested in this section is summarized in the table below. Label all documentation as described in the table.

<table>
<thead>
<tr>
<th>Document</th>
<th>Details</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim/Encounter or Supplemental Baseline Questions</td>
<td>Complete Attachment 2.1: Medical Data Baseline Questions.</td>
<td>2.1</td>
</tr>
<tr>
<td>Claim/Encounter or Supplemental Data System Flowchart</td>
<td>Provide a flowchart that gives an overview of the claim/encounter or supplemental data system and processes, indicating steps in the process as well as the flow of claim/encounter or supplemental data from all sources.</td>
<td>2.2</td>
</tr>
<tr>
<td>Proprietary Forms (if applicable)</td>
<td>If proprietary claim/encounter or Supplemental forms were used during the measurement year, attach clean, blank copies of each.</td>
<td>2.3</td>
</tr>
<tr>
<td>Explanation of Nonstandard Code (if applicable)</td>
<td>If nonstandard codes were used during the measurement year, attach descriptions of internally developed codes, code definitions, translation procedures and code mapping schemes.</td>
<td>2.4</td>
</tr>
<tr>
<td>Supplemental Database Files</td>
<td>For each supplemental database used, provide file layouts, blank and completed.</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Contacts

Provide the name, title, company, address, telephone and fax numbers and e-mail address of the persons responsible for completing this section of the BAT.

<table>
<thead>
<tr>
<th>Name</th>
<th>Primary Audit Contact</th>
<th>Secondary Audit Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Company</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City, state, zip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E-mail address</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date of completion:
Attachment 2.1: 
Medical Data Baseline Questions

Completing this attachment is required once for each PO and vendor claim/encounter or supplemental data processing system, and thereafter if the processes or systems change, if a new audit firm is used or if the audit firm requests it.

General Information

PO Name:

1. In Table 2.1A, provide information about the claim/encounter or supplemental data processing system described in this section.

2. In Table 2.1B, indicate the name of each vendor used to process or maintain all or part of your PO’s claim/encounter or supplemental data during the measurement year. Consider all external entities to which your PO delegated any or all aspects of claim/encounter or supplemental data processing. Indicate variations among product lines/products, as appropriate.

Table 2.1A: Medical Data Processing System

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Claim/Encounter or supplemental data System</td>
<td></td>
</tr>
<tr>
<td>Type of Data Processed</td>
<td></td>
</tr>
<tr>
<td>Location: (city, state)</td>
<td></td>
</tr>
</tbody>
</table>

Table 2.1B: Claims Processing Vendors

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Functions delegated</th>
<th>Product lines/products affected</th>
<th>Percentage of members affected</th>
<th>Contract start/end date</th>
<th>Method and frequency of transmitting membership data to the health plan</th>
</tr>
</thead>
</table>

Medical Data System

2. In Table 2.2A, indicate whether a data element is:

- **R** Required: The claim/encounter or supplemental data system requires the data element for all claims/encounters or supplemental data.
- **O** Optional: The claim/encounter or supplemental data system requires the data element for some claims/encounters or supplemental data, but not for all claims/encounters or supplemental data.
- **N** Not Required: The claims/encounter or supplemental data system does not require or capture the data element.
- **NA** Not Applicable: The data element does not apply to the claim/encounter or supplemental data system
Explain **O**, **N** or **NA** data elements. If responses vary by product line/product, explain.

**Table 2.2A: Medical Data Element Requirements**

<table>
<thead>
<tr>
<th>Required? (R, O, N, NA)</th>
<th># of Codes</th>
<th># of Digits</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Identification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rendering Practitioner Identification</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Claims Information**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Claim Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Date of Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Date of Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payment Status</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Codes**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure Modifiers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRG (if no hospital data used, state NA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Bill</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCPCS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOINC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT Level II</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Does the claim/encounter or supplemental data system use automated coding software to:
   a. Verify procedure or diagnosis codes? If so, describe.
   b. Group or ungroup procedure or diagnosis codes? If so, describe.
   c. Ensure the accurate assignment of DRGs (if available)? If so, describe.

4. Describe the claim/encounter or supplemental data system’s built-in edit checks, including checks on parity, field sizes, date ranges and cross checks with member and practitioner files.

**Medical Data Processes**

5. How are claims/encounters or supplemental data obtained, processed and entered into the claim/encounter or supplemental data system? Describe how data are processed.

6. Are encounters (e.g., submissions that are not linked to payment) processed differently from claims (e.g., submissions for payment)? If so, describe.

7. How is a claim/encounter or supplemental data handled if it is submitted:
   a. With one or more required fields missing, incomplete or invalid?
   b. With no diagnosis code, or an invalid code? Is a default code used?
c. With no procedure code, or an invalid code? Is a default code used?

8. Describe the circumstances under which processors can change claim/encounter or supplemental data information submitted by a provider.

9. Describe how new claim/encounter or supplemental data processing staff are trained.

### Electronic Submission of Claim/Encounter or Supplemental Data

If the claim/encounter or supplemental data system accepts electronically transferred claim/encounter or supplemental data, answer the following questions.

10. How are electronically received files uploaded into the claim/encounter or supplemental data processing system?

11. Do electronically received claims/encounters or supplemental data undergo the same edits checks as paper claims/encounters or supplemental data?

12. Describe the procedures that ensure that transmissions are properly monitored and controlled.

13. What edit checks are performed to ensure that electronically transferred claim/encounter or supplemental data files are accurately and completely received and uploaded?

14. How do you verify the accuracy of electronic submissions?

### Contacts

Provide the name, title, company, address, telephone and fax numbers and e-mail address of the persons responsible for completing this section of the BAT.

<table>
<thead>
<tr>
<th>Name</th>
<th>Primary Audit Contact</th>
<th>Secondary Audit Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Company</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City, state, zip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E-mail address</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Date of completion:**
Section 3: Medical Data—Data Completeness (IS 2.4)

This section requests information on the completeness of your PO’s measurement year claim/encounter or supplemental data. Keep in mind:

- All questions relate to your measurement year systems and processes, unless otherwise indicated.
- As indicated, comparable internal reports can be submitted in lieu of completing tables. Work with your auditor to determine if your PO’s internal documentation is suitable for submission.

PO Name:

Vendor Data Arrangements

1. In Table 3.1, enter the name of each vendor (e.g., MSO) used to process or maintain your PO’s claim/encounter or supplemental data during the measurement year. Consider all external entities that your PO delegated any claim payment/encounter or supplemental data processing during the measurement year. Do not include vendors who were only responsible for data entry functions.

   Work with your Certified HEDIS Compliance Auditor to determine which vendors should be included in this table. For each vendor, indicate:

   a. Type of payment arrangement (e.g., partial risk, full risk) between the PO and the vendor during the measurement year.

   b. Type of service provided by the vendor (e.g., MSO) during the measurement year.

   c. Approximate percentage of patients whom the vendor was responsible for providing services to during the measurement year. If the percentage varied, provide a range.

   d. Approximate date of contract initiation and termination, if applicable (month/year).

   e. Average per member per year (PMPY) count of claims/encounters or supplemental data, with dates of service during the measurement year, received from the vendor.

   f. Average PMPY count of claims/encounters or supplemental data, with dates of service during the measurement year, which will be considered for the measurement year P4P clinical report (i.e., integrated in the data warehouse or repository). If the information is not available at time of BAT completion, submit it on a later date.

Table 3.1: Medical Data Processing Vendors

<table>
<thead>
<tr>
<th>Commercial HMO/POS</th>
<th>Vendor Name</th>
<th>Payment Arrangement</th>
<th>Type of Service(s) Provided</th>
<th>Percent of Members Affected</th>
<th>Contract Start/End Date</th>
<th>Average PMPY Claims/Encounters or supplemental data Received</th>
<th>Average PMPY Claims/Encounters or supplemental data Considered for P4P</th>
</tr>
</thead>
</table>

2. Describe data completeness or data quality issues identified for vendors indicated in Table 3.1.
Assessment of Data Completeness

3. For claim/encounter or supplemental data received from practitioners, facilities and vendors:
   a. How does your PO monitor and assess the completeness of data submitted?
   b. How often does your PO monitor and assess the completeness of data submitted?
   c. Has your PO established benchmarks to assess the completeness of data submitted? If so, describe.

4. Has your PO conducted additional studies or analyses of data completeness or under-reporting? If so, describe.

5. Describe barriers to obtaining complete and accurate claim/encounter or supplemental data. Consider all factors that might influence your ability to collect such information from practitioners and contracted vendors, including, but not limited to, vendor system constraints or incompatibilities, lack of reporting requirements, capitation arrangements and data integration issues.

6. In Table 3.2, enter the average PMPY count of claims/encounters or supplemental data considered for the measurement year (e.g., integrated in the P4P data warehouse or repository). If the information is not available at BAT completion, submit it on a later date. Comparable internal reports may be submitted in lieu of Table 3.2.

   Table 3.2: Completeness of Claim/Encounter or Supplemental Data

<table>
<thead>
<tr>
<th>Type of Service:</th>
<th>PMPY Count of Claims/Encounters or Supplemental Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prior Year</td>
</tr>
<tr>
<td>Ambulatory</td>
<td></td>
</tr>
<tr>
<td>Inpatient (if applicable)</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td></td>
</tr>
</tbody>
</table>

7. To determine the PMPY count, indicate how each type of service listed in Table 3.2 was identified.

Improvement of Data Completeness

8. What steps, if any, has your PO taken to improve completeness of claim/encounter or supplemental data?

9. During the measurement year:
   a. Were all practitioners, facilities and vendors required by contract to submit complete and accurate claim/encounter or supplemental data?
   b. Were performance standards in place to ensure submission of claim/encounter or supplemental data by practitioners, facilities and vendors? Describe.
   c. Was compensation tied to submission of claim/encounter or supplemental data by practitioners, facilities and vendors? Describe.
   d. Were other incentive or penalty arrangements in place for practitioners, facilities and vendors to submit complete and accurate data? Describe.
   e. Were other activities undertaken to encourage claim/encounter or supplemental data submission by practitioners, facilities and vendors? Describe.

10. What action, if any, was taken for practitioners, facilities and vendors who routinely failed to submit complete and accurate claim/encounter or supplemental data?
Requested Supporting Documentation

The documentation requested in this section is summarized in the table below. Label all documentation as described in the table.

<table>
<thead>
<tr>
<th>Document</th>
<th>Details</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Lag, IBNR and/or Completion Factor Reports</td>
<td>Provide documentation (e.g., claim lag reports, IBNR reports, completion factor reports) of completeness of claim/encounter or supplemental data at the time data files were generated for P4P reporting.</td>
<td>3.1</td>
</tr>
<tr>
<td>Data Completeness Studies and/or Analyses</td>
<td>If applicable, attach copies of additional studies or analyses conducted on data completeness or under-reporting.</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Contacts

Provide the name, title, company, address, telephone and fax numbers and e-mail address of the persons responsible for completing this section of the PO BAT.

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Date of completion:
Section 4: Membership Data Processing (IS 3)

This section requests information on the membership data systems and processes used during the measurement year. Complete this section annually for each PO (or vendor if handled by an MSO) membership data processing system.

A membership processing vendor includes any external entity with which the PO has contracted to perform membership data processing functions (e.g. MSO). Complete a separate Section 5 for each vendor membership data processing system used for P4P reporting. Keep in mind that all questions relate to the systems and processes used during the measurement year, unless otherwise indicated.

PO Name:

Membership Measurement Year Questions

General Information

1. For the commercial HMO/POS product under review during the measurement year, what data systems were used:
   a. Process membership data?
   b. Ensure eligibility when processing claims/encounters or supplemental data?
   c. Maintain other membership data? Describe.

2. In Table 4.1, indicate the year-end membership with P4P plans for the past three years.

Table 4.1: Year-End Membership

<table>
<thead>
<tr>
<th>Product:</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product Line:</td>
<td>HMO/POS</td>
</tr>
</tbody>
</table>

- 2 Years Prior to Measurement Year (MY)
- 1 Year Prior to MY
- Measurement Year

3. During the measurement year, did the commercial HMO/POS product under review experience a large change in membership? If so, describe.

4. Were changes implemented during the measurement year to improve your membership data quality, processing or system? If so, describe.
Membership Data Processing

5. Regarding timeliness of membership data processing during the measurement year, once data are received from the plans:
   a. What was the actual average time to process for membership data?
   b. Was there ever a backlog or delay in processing membership data? If so, describe.
   c. Was there ever a backlog or delay in receiving membership data from health plans? If so, describe.

6. Regarding accuracy of membership data processing during the measurement year:
   a. Were audits of membership data processing conducted? If so, describe what was audited and how often.
   b. What were your findings for the measurement year?
   c. Were deficiencies detected? If so, describe.

7. During the measurement year, were membership data reconciled against an external data source (e.g., health plan data)? If so, answer the questions below.
   a. Describe the reconciliation process, including what was reconciled and how often.
   b. What were your findings for the measurement year?
   c. Were deficiencies detected? If so, describe.

8. During the measurement year, were staff incentives tied to the accuracy and timeliness of membership data processing? If so, describe.

9. Describe barriers to obtaining complete and accurate membership data. Consider all factors that might influence your ability to collect such information from health plans.

System Upgrades/Conversions

If during the past three years major changes, upgrades or consolidations were implemented in the membership data system or a new enrollment/membership data system implemented for the commercial HMO/POS population, answer the following questions. If your membership system is encompassed within your claims/encounter system, you may skip these questions because they were answered in Section 2.

10. What membership data systems and product lines/products (e.g. commercial HMO/POS) were affected?

11. What were the dates of project initiation and completion?

12. Regarding conversion of data:
   a. What members were converted to the new system (e.g., active members only, all members)?
   b. What members were not converted to the new system?
   c. What data elements were converted to the new system?
   d. What data elements were not converted to the new system?

13. Describe the data mapping used to convert data from the previous to the new membership system.

14. How was data accuracy and completeness in the new system ensured?
Vendor Oversight

If vendors were used to process membership data during the measurement year, answer the following questions.

15. Describe the standards of delegation, if any, that vendors were subject to during the measurement year, including oversight policies, processing standards and predelegation requirements.

16. Describe the reporting requirements, if any, that vendors were subject to during the measurement year, including type and frequency of reporting.

17. Describe the oversight and monitoring activities, if any, that vendors were subject to during the measurement year, including type and frequency of reviews/audits.

18. During the measurement year, were deficiencies detected with vendor processing of membership data? If so, describe the nature of the deficiencies and corrective actions taken.

Requested Documentation

The documentation requested in this section is summarized in the table below. Label all documentation as described in the table.

<table>
<thead>
<tr>
<th>Document</th>
<th>Details</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership Data System Flowchart</td>
<td>Provide a flowchart that gives an overview of the membership data system and processes, indicating steps in the membership data process as well as the flow of membership data from all sources.</td>
<td>4.1</td>
</tr>
</tbody>
</table>

Contacts

Provide the name, title, company, address, telephone and fax numbers and e-mail address of the persons responsible for completing this section of the PO BAT.

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Date of completion:
Section 5: Integration of Data for P4P Reporting (IS 4)

This section requests information on how your PO integrates claim/encounter, supplemental data and membership vendor and other data to calculate P4P clinical rates for the measurement year. Keep in mind that all questions relate to your measurement year systems and processes, unless otherwise indicated.

General Information

PO Name:

1. In Table 5.1, indicate the type of staff responsible for key steps in the P4P measure production process. Enter the number of individuals responsible for each step, providing vendor names and explanations where relevant.

Table 5.1: Data Integration and Report Production

<table>
<thead>
<tr>
<th>P4P Production Functions</th>
<th>PO Staff</th>
<th>Vendor(s)</th>
<th>Contracted Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data integration</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Data warehouse/repository</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Source code development</td>
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<td></td>
<td></td>
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<tr>
<td>Rate calculation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project management</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other (indicate)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Provide an overview of how data is integrated and consolidated for P4P reporting. Consider data from all sources and indicate whether rates are calculated by querying the processing system online, creating extract files or through a separate database, data repository or warehouse.

Data Integration

3. In Tables 5.2 indicate the data files used for the measurement year and the date on which the file was loaded into the repository, and dates for planned data refresh, for P4P reporting. Consider data received from vendors and any other external sources. Complete multiple tables if variations among products exist and add columns and rows, as appropriate.

Table 5.2: P4P Data Files

<table>
<thead>
<tr>
<th>Membership:</th>
<th>Date Loaded Into Repository or P4P Data Source</th>
<th>Date of Most Recent Data Refresh</th>
<th>Date of Planned Final Data Refresh</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim/encounter:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pharmacy</td>
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<td></td>
<td></td>
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<tr>
<td>• Laboratory</td>
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<td></td>
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<tr>
<td>• Lab results</td>
<td></td>
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<td></td>
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<tr>
<td>• Public registry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Supplemental database(s) (list all if applicable):
### Table 5.3: Data Refresh

Table 5.3 examines the source of data for measures and the date of the last refresh prior to running each measure.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Vendor or External Data Included?</th>
<th>Dates of Data Refresh</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounter Rate by Service Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Immunization Status – 24 Month Continuous Enrollment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate Treatment for Children With Upper Respiratory Infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol Management for Patients With Cardiovascular Conditions – LDL Screening</td>
<td></td>
<td></td>
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<tr>
<td>Cholesterol Management for Patients With Cardiovascular Conditions – LDL Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Care – HbA1c Testing</td>
<td></td>
<td></td>
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<tr>
<td>Diabetes Care – HbA1c Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Care – LDL Screening</td>
<td></td>
<td></td>
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<tr>
<td>Diabetes Care – LDL Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Care – Nephropathy Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of Appropriate Medications for People With Asthma</td>
<td></td>
<td></td>
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<tr>
<td>Colorectal Cancer Screening</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Transition Measures, Optional for Reporting:**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Vendor or External Data Included?</th>
<th>Dates of Data Refresh</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate Treatment for Children With Pharyngitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis</td>
<td></td>
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<tr>
<td>Use of Imaging Studies for Low Back Pain</td>
<td></td>
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<tr>
<td>Annual Monitoring for Patients on Persistent Medications</td>
<td></td>
<td></td>
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<tr>
<td>Diabetes Care - HbA1c Good Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potentially Avoidable Hospitalizations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Testing Measures, Optional for Reporting:**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Vendor or External Data Included?</th>
<th>Dates of Data Refresh</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Readmission Within 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression Screening and Assessment for High-Risk Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma Medication Ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence-Based Cervical Cancer Screening of Average-Risk, Asymptomatic Women</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. If some or all membership or claim/encounter data were excluded from P4P reporting, answer the following questions. Consider all external entities to which your PO delegated any or all aspects of data processing.
   a. What data were excluded?
   b. What percentage of members, practitioners or claims/encounters was affected?
   c. Why were the data excluded from P4P reporting?
Appendix 1—PO Baseline Assessment Tool: Section 5  1-25

File Consolidation

5. Describe the procedures used to link:
   a. Claim/encounter (including vendor) or supplemental data and membership data.
   b. Multiple claim/encounters for a single inpatient stay.

6. Regarding how you ensure the accuracy of data integrated for P4P reporting:
   a. Describe your process to monitor that the required level of coding detail is maintained.
   b. Describe how you identify and handle duplicate records.
   c. Describe how you identify and handle erroneous data.
   d. Describe how you identify and handle missing data elements.
   e. Describe how you ensure that the repository/warehouse accurately reflects the transaction files.
   f. Describe how you ensure that no data was lost in the data integration process.
   g. Describe algorithms used to check the reasonableness of data integrated to report P4P.

7. If your PO employs nonstandard codes, describe how they are translated back to standard codes for P4P reporting. Include a copy of your code mapping scheme and translation procedures.
Requested Supporting Documentation

The documentation requested in this section is summarized in the table below. Label all documentation as described in the table.

<table>
<thead>
<tr>
<th>Document</th>
<th>Details</th>
<th>Label</th>
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<tbody>
<tr>
<td>Data Integration Flow Chart</td>
<td>Provide a flowchart that gives an overview of your management information systems structure, including how all claims, encounter, supplemental data, membership, provider and vendor data are integrated for P4P reporting.</td>
<td>5.1</td>
</tr>
<tr>
<td>P4P Repository File Structure (if applicable)</td>
<td>Provide a complete file structure, file format and field definitions for your P4P repository.</td>
<td>5.2</td>
</tr>
<tr>
<td>Mapping of Nonstandard Codes</td>
<td>If your PO employs nonstandard codes, provide the mapping scheme used to translate those codes to standard codes for P4P reporting (if applicable).</td>
<td>5.3</td>
</tr>
<tr>
<td>Source code development assignments (if non-certified software vendor is used)</td>
<td>Provide a list of measures and the programmer assigned to its source code development.</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Contacts

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Date of Completion:
Section 6: Control Procedures to Ensure P4P Clinical Data Integrity (IS 5)

This section requests information on how your PO manages its P4P clinical report production process, maintains its software and ensures data integrity. Keep in mind that all questions relate to your measurement year systems and processes, unless otherwise indicated.

PO Name:

P4P Clinical Report Software

1. List the software packages, programming languages and mainframe/PC-based application programs your PO or vendor uses to prepare and calculate the measurement year P4P clinical report. Consider all programs, not just the final application - used to create denominators, numerators and samples.

2. Regarding the P4P clinical programming staff responsible for developing the measurement year source code:
   a. How many individuals are involved in developing the source code?
   b. What is their experience and relevant background?
   c. How is their work overseen and monitored?

3. Describe the process for producing source code for the measurement year, including development, oversight, review, testing and version control.

Report Production

4. Describe the processes for running P4P production reports for the measurement year, including production control mechanisms, job logs, supervisory review, error detection and re-runs.

5. Describe the tests and checks performed to validate the accuracy and completeness of:
   a. Measure-specific rates.
   b. Measure-specific denominators (i.e., eligible member population).

6. Regarding how continuous enrollment was calculated for the measurement year:
   a. Describe how your continuous enrollment logic tracks membership history, including separate coverage periods, change in identification number, change in relationship to subscriber or plan.
   b. Describe any system or data limitation that precludes full implementation of P4P clinical measure continuous enrollment requirements as specified.
System Security

7. Regarding control procedures in place during the measurement year for your P4P rate production and data repository/warehouse:
   a. How often are back-ups conducted? Are they maintained onsite or offsite?
   b. How is data-access authorization assigned?
   c. What type of uninterruptible power supply (UPS) is available?
   d. What type of physical security, including fire protection, is in place?

8. Regarding control procedures in place during the measurement year for your PO’s claim/encounter, supplemental data, membership and practitioner data processing systems:
   a. How often are back-ups conducted? Are they maintained onsite or offsite?
   b. How is data-access authorization assigned?
   c. What type of UPS is available?
   d. What type of physical security, including fire protection, is in place?

9. For the measurement year, have you:
   a. Restored data from back-up files? If so, explain.
   b. Experienced data loss? If so, explain.

Requested Supporting Documentation

The documentation requested in this section is summarized in the table below. Label all documentation as described in the table.

<table>
<thead>
<tr>
<th>Document</th>
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<tbody>
<tr>
<td>Disaster Recovery/ Routine Back-Up Processes</td>
<td>Provide documentation that describes your disaster recovery and routine back-up processes.</td>
<td>6.1</td>
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Contacts

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Date of Completion:

MY 2007 P4P Manual
Section 7: Outsourced or Delegated P4P Report Functions (HD 5)

This section requests information on how your PO ensures the quality of P4P data collected or processed by vendors for the measurement year. Keep in mind that all questions relate to your measurement year systems and processes, unless otherwise indicated.

PO Name:

P4P Data Integration or Rate Production Vendors

1. Complete the following questions if, for the measurement year, any vendors or other external entities were responsible for integrating data for the P4P clinical report, maintaining the data repository, developing source code for P4P clinical rate calculation or calculating individual rates, denominators or numerators. Include any relevant contract language and written standards or requirements.
   a. For each vendor, describe delegated functions.
   b. Describe how your PO ensures the accuracy and completeness of data received from vendors.
   c. Describe how your PO ensures that vendors meet P4P clinical report standards and time frames.
   d. Describe how your PO monitors vendor performance.
   e. Describe any areas of deficiency discovered for the measurement year rates.

Claim/Encounter Data Processing Vendors

2. Complete the following questions if, for the measurement year, any vendors or other external entities were responsible for processing of claim/encounter data. A claim/encounter processing vendor includes any external entity with which the PO has contracted to provide a particular type of service (e.g., lab or radiology) or perform claim/encounter data processing functions. Vendors may include, but are not limited to, ancillary providers, provider specialty groups, and intermediary organizations (e.g., MSOs). Include any relevant contract language and written standards or requirements.
   a. For each vendor, describe delegated functions.
   b. Describe the standards of delegation, if any, that vendors were subject to during the measurement year, including oversight policies, processing standards and predelegation requirements.
   c. Describe the reporting requirements, if any, that vendors were subject to during the measurement year, including type and frequency of reporting.
   d. Describe the oversight and monitoring activities, if any, that vendors were subject to during the measurement year, including type and frequency of reviews/audits.
   e. Describe how your PO ensures the accuracy and completeness of claim/encounter data received from vendors.
   f. Describe how your PO provides vendors with membership data.
   g. Describe any areas of deficiency discovered for the measurement year.
Requested Supporting Documentation

The documentation requested in this section is summarized in the table below. Label all documentation as described in the table.

<table>
<thead>
<tr>
<th>Document</th>
<th>Details</th>
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<tbody>
<tr>
<td>Vendor requirements</td>
<td>Provide excerpts from vendor contracts or other documentation that indicate requirements for:</td>
<td>7.1</td>
</tr>
<tr>
<td></td>
<td>• Frequency and timeliness of reporting to your PO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Accuracy and completeness of data reported to your PO</td>
<td></td>
</tr>
<tr>
<td>Documentation of vendor</td>
<td>Provide documentation of how your PO monitors vendors against contract requirements for timeliness, accuracy and completeness of data.</td>
<td>7.2</td>
</tr>
<tr>
<td>monitoring</td>
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Contacts

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Date of Completion:
Appendix 2

PO Data Source Documentation
APPENDIX 2

PO DATA SOURCE DOCUMENTATION

During a P4P Audit Review, the CHCA reviews a number of data sources and processes to assess the PO’s information systems and measure compliance. Although auditors use their experience and discretion to select which data sources to review, NCQA recommends that all applicable items be evaluated during an initial audit engagement. The PO should ensure that the following data sources are available for the CHCA to review.

Documents and Processes for Auditor Review

- All forms for submitting medical data *(IS 2)*
- Calculation code *(HD 3)*
- Computer operations and system security schemes *(IS 4, IS 5)*
- Control system documentation, including flow charts and codes for backups, recovery, archiving and other control functions *(IS 5)*
- Copies of standard monitoring reports for all operations personnel including data entry, claims processing, member and practitioner file clerical staff and hardware operations *(IS 2–IS 5)*
- Data completeness studies *(IS 2)*
- Data entry procedure manuals *(IS 2–IS 3)*
- Data entry forms and screens *(IS 2–IS 3)*
- Data entry process for membership, claims and encounters *(IS 2–IS 3)*
- Data submission policies *(IS 1)*
- Denominator records based on transaction data review *(HD 2)*
- Description of software or programming languages used to query each database *(HD 4)*
- Descriptive documentation for data entry, data transfer, data manipulation programs and processes *(IS 2–IS 4)*
- Detailed (line by line) programming or administrative query procedure *(HD 5)*
- Edit lists that display and explain all edit failures and the messages that accompany them *(IS 2–IS 5)*
- Electronic formats and protocols *(IS 2–IS 5)*
- Electronic transmission procedures documentation *(IS 2–IS 5)*
- Files used to collect transaction data electronically *(IS 1–IS 3)*
- P4P reporting repository *(IS 4)*
- Instruction and forms for employers for submitting member-level information regarding additions, deletions and changes *(IS 3)*
- Instructions for submitting files of electronic claims and encounters *(IS 2)*
- Log forms for all system hardware activities, including back-up, failure response and recovery, system optimization techniques *(IS 5)*
- Log forms for submission and receipt of data—manual and electronic *(IS 2–IS 3)*
- Log forms for mapping and linking processes to prepare data for HEDIS reporting *(IS 1–IS 4)*
• Manuals covering application system development methodology, database development and design and decision support-system utilization (IS 4, IS 5)

• Manuals describing procedures for monitoring hardware function, capacity, physical states and access (IS 5)

• Medical data submission (IS 2)

• Nonstandard coding schemes and mapping documents linking to standard codes (IS 1)

• Numerator events based on transaction data review (HD 2)

• Operator performance reports that display for each operator and processor their accuracy and productivity for a given time period (IS 2–IS 4)

• Parameter transfer, including output and rate calculation input (HD 3)

• Record and file formats and descriptions for entry, intermediate and repository files (IS 4)

• Source code and output files for measures (HD 5)

• System and data flow charts that describe processes in pseudocode format (IS 2–IS 4)

• System modification documentation (if applicable) (IS 1–IS 4)

• Training material and procedure manuals for claims/encounter data entry and membership data entry staff (IS 2–IS 3)

• Transaction files (IS 2–IS 3)

• Vendor administrative databases, policies and procedures (HD 5)

• Vendor data collection tools and instructions (HD 5)

• Vendor data submissions (HD 5)

• Vendor update documents (HD 5)
Appendix 3

Auditor’s Decision Point Grid
## APPENDIX 3

### AUDITOR’S DECISION POINT GRID

*(To be completed by the auditor)*

**Instructions**

**Step 1**
For each HD standard for which all audit elements are compliant, enter FC (Fully Compliant) in the *Issue* column. Skip to the *Verified* column and provide information on how the standard was validated (source code review, data query, etc.).

**Step 2**
For each audit element identified as “No,” discuss the problem under the corresponding HD Standard in the *Issue* column and state whether or not it introduced a significant bias. Provide the appropriate information in the next two columns. Indicate what type of corrective action was required and the resolution (e.g., the PO made recommended changes; the rate was recalculated and the auditor validated that the changes were made; the issue did not introduce significant bias).

**Step 3**
The CHCA should tailor the Decision Point Grids to include all specifications for each measure evaluated.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Standard</th>
<th>Component</th>
<th>Audit Element</th>
<th>Fully Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HD 1</td>
<td>Denominator</td>
<td>Product line</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Product</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Age and gender</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinical codes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Event driven—data completeness</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>All appropriate data used</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HD 2</td>
<td>Numerator</td>
<td>Clinical codes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Time period for clinical events</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Age and gender</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Event</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rate/Percentage calculation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>All appropriate data used</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HD 3</td>
<td>Algorithmic Compliance</td>
<td>Algorithmic compliance</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>HD 4</td>
<td>Documentation</td>
<td>Data processes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HD 5</td>
<td>Vendor</td>
<td>Vendor data collection</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PO’s QI monitoring</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Documentation data processes</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 3—Auditor’s Decision Point Grid

### Comments

<table>
<thead>
<tr>
<th>HD</th>
<th>Issue</th>
<th>Corrective Action</th>
<th>Resolution or Verified</th>
</tr>
</thead>
<tbody>
<tr>
<td>HD 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HD 2</td>
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<td></td>
<td></td>
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<tr>
<td>HD 3</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>HD 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HD 5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4

PO IS Standards Compliance Tool
# APPENDIX 4

## PO IS STANDARDS COMPLIANCE TOOL

*(To be completed by the auditor)*

### IS Standards Compliance Tool Instructions

This tool is used by Certified HEDIS Compliance Auditors to determine PO compliance with IS standards and if there is an impact on P4P reporting. A completed copy of this tool must appear in the auditor’s work papers. The last column indicates the IS system’s designation:

- **S** = Significant impact on P4P reporting
- **M** = Minimal impact on P4P reporting
- **N** = No impact on P4P reporting

### IS Standards Audit Team Participants

<table>
<thead>
<tr>
<th>Standard</th>
<th>Audit Activities</th>
<th>P4P reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Describe Validation Method</td>
<td>Validation Results and Date Completed</td>
</tr>
<tr>
<td><strong>IS 1.0  SOUND CODING METHODS FOR MEDICAL DATA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS 1.1 Industry standard codes (ICD-9, CPT, DRG, HCPCS, etc.) are used consistently and all characters are collected and captured.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS 1.2 Principal codes are identified and secondary codes are captured. Nonstandard coding schemes are fully documented and mapped back to industry standard codes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IS 2.0  DATA CAPTURE, TRANSFER AND ENTRY—MEDICAL DATA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS 2.1 Standard submission forms are used routinely and capture all fields relevant to P4P reporting. All nonstandard forms capture equivalent data.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS 2.2 Data receipt and entry processes are effective and efficient and ensure timely, accurate and complete input to P4P clinical reporting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS 2.3 Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off and sign-off).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## IS Standards Audit Team Participants (continued)

<table>
<thead>
<tr>
<th>Standard</th>
<th>IS 2.0 DATA CAPTURE, TRANSFER AND ENTRY—MEDICAL DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IS 2.4 Data completeness is assessed on an ongoing basis and steps are taken to improve performance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard</th>
<th>IS 3.0 DATA CAPTURE, TRANSFER AND ENTRY—MEMBERSHIP DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IS 3.1 The PO has procedures for handling measure-relevant information for data entry and for ensuring accurate, complete and timely entry of membership data.</td>
</tr>
<tr>
<td></td>
<td>IS 3.2 Data entry processes are effective, efficient, timely and include sufficient edit checks to ensure accurate reflection of submitted data in transaction files.</td>
</tr>
<tr>
<td></td>
<td>IS 3.3 Electronic transmissions of membership data have necessary checking procedures to ensure accuracy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard</th>
<th>IS 4.0 DATA INTEGRATION REQUIRED TO MEET THE DEMANDS OF ACCURATE MEASURE REPORTING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IS 4.1 Data transfers to measure repository from transaction files are accurate.</td>
</tr>
<tr>
<td></td>
<td>IS 4.2 File consolidations, extracts and derivations are accurate.</td>
</tr>
<tr>
<td></td>
<td>IS 4.3 Repository structure and formatting are suitable for P4P clinical measures and enable required programming efforts.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard</th>
<th>IS 5.0 CONTROL PROCEDURES THAT SUPPORT P4P REPORTING INTEGRITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IS 5.1 Report production is managed effectively and operators perform appropriately.</td>
</tr>
<tr>
<td></td>
<td>IS 5.2 P4P clinical reporting software is properly managed with regard to development, methodology, documentation, revision control and testing.</td>
</tr>
<tr>
<td></td>
<td>IS 5.3 Physical control procedures are in place to ensure P4P data integrity, such as physical security, data access authorization, disaster recovery facilities, UPS and fire protection.</td>
</tr>
</tbody>
</table>
APPENDIX 5
GLOSSARY

accuracy | The extent to which recorded data (on forms and computer databases) are error-free and reflect the defining events. Error sources are miscoding, misrepresenting facts, maintaining out-of-date findings, recording data for the wrong person, data entry errors and computer programming errors.

administrative database | Any automated data, including claims and encounter systems used by the PO or health plan to manage the delivery of health services to members.

administrative methodology | Requires the PO and health plan to identify a measure denominator and numerator using transaction data or other administrative databases.

anchor date | A date on which the member must be enrolled with the PO. No gaps in enrollment may include this date.

audit result | Defines the suitability of measures for reporting. These results include Report and Not Report.

attestation | A statement ensuring the validity of a report or document (e.g., data submission file attestation, BAT attestation).

bias (degree of bias) | Degree of error. P4P rate measures are reported using a 95 percent confidence interval. A greater than 5 percent error in the reported rate is considered materially biased and receives a Not Report.

bundling | When the PO accepts a single code as representative of several services or encounters. For example, prenatal care visits are bundled with delivery, or all hospital services may be under the revenue code for room and board.

carve out | An arrangement under which services (e.g., mental health or laboratory) are contracted to a third party by the PO, health plan or employer.

claims audit/error rate | A rate that indicates the reliability of a claims processing system. Most POs review a sample of claims after they are processed to compute an error rate, usually expressed as financial and nonfinancial.

claims dependent denominator | To determine the eligible population through claims data (e.g., diabetic members are identified by claims showing diagnoses for diabetes or dispensing of insulin).

comprehensive data | Complete records of patient care. Information about a member’s every encounter with the health care system.

concurrent audit | Evaluation of methods and data during the data collection period. P4P Audit Reviews take place during data collection, allowing POs to correct errors before data are reported.

continuous enrollment | The minimum amount of time, including allowed gaps, that a member must be enrolled in the PO and/or health plan to be eligible for the measure.

corrective action | An activity the PO or plan completes between the onsite visit and data submission to correct problems that may result in a Not Report.

database | Data collected and organized in a computer file for ease of expansion, updating and retrieval.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>data completeness</td>
<td>Determination or evaluation of missing data. Data-completeness issues must be quantified, and Not Report must be supported by determination of material bias.</td>
</tr>
<tr>
<td>data completeness assessment</td>
<td>An assessment of the impact of claims lag, encounter data submission rates and studies on PO and/or health plan data completeness.</td>
</tr>
<tr>
<td>data consolidation</td>
<td>A combination of data from multiple sources, such as multiple electronic sources or electronic and medical record sources.</td>
</tr>
<tr>
<td>data extraction</td>
<td>Collecting data from medical records or pulling data from electronic and automated systems.</td>
</tr>
<tr>
<td>data integration</td>
<td>A combining of data from multiple sources, with additional steps that ensure that duplicate data are removed and that the data is refined.</td>
</tr>
<tr>
<td>data integrity</td>
<td>Data that are unimpaired and not altered or destroyed, accidentally or intentionally.</td>
</tr>
<tr>
<td>data reliability</td>
<td>A measure of data consistency based on reproducibility and an estimation of measurement error.</td>
</tr>
<tr>
<td>delegate</td>
<td>A formal process by which the PO or health plan gives another entity the authority to perform certain functions on its behalf, such as provision of mental health care or laboratory services.</td>
</tr>
<tr>
<td>deviation</td>
<td>Any process that does not strictly comply with P4P standards as published by NCQA. All deviations must be documented in writing to NCQA before an audit.</td>
</tr>
<tr>
<td>DMHC</td>
<td>Department of Managed Health Care; the licensing body for managed care in California that oversees all full and partial Knox Keene licensed health care organizations.</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic data interface. Standard electronic formats used for collecting data that are imported into or exported from various systems.</td>
</tr>
<tr>
<td>external administrative database</td>
<td>Automated data supplied by contracted practitioners, vendors or public agencies (e.g. immunization registries, schools or state public health agencies).</td>
</tr>
<tr>
<td>FAQ</td>
<td>Frequently asked questions posted to the NCQA Web site on the 15th of each month.</td>
</tr>
<tr>
<td>P4P repository</td>
<td>A database or file system that stores all the P4P information, including claims and membership and which may be updated during the data collection period.</td>
</tr>
<tr>
<td>health plan</td>
<td>An organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>homegrown code</td>
<td>A diagnosis or procedure code not recognized nationally but used by the PO or health plan. Commonly found in mental health and preventive care. Some POs and health plans continue to accept obsolete codes as homegrown codes after they are deleted from coding books.</td>
</tr>
<tr>
<td>HMO</td>
<td>Health maintenance organization. See health plan.</td>
</tr>
<tr>
<td>inclusiveness</td>
<td>The extent to which an entire population or defined group is intentionally included in a database.</td>
</tr>
<tr>
<td>industry standard code</td>
<td>A code used by the majority of health care facilities and providers. P4P measures use these codes in the specifications (CPT, ICD-9-CM, DRG, CMS1500 Place of Service codes, UB-92 Type of Bill, Revenue codes).</td>
</tr>
<tr>
<td>internally built database</td>
<td>A PO-created database containing claims or medical record information. These databases are often designed for other purposes and, if used for measure collection, are subject to audit. Examples include case management databases, utilization management databases or databases populated with medical record information.</td>
</tr>
<tr>
<td>map</td>
<td>A document showing how the PO or health plan cross-references homegrown codes to codes specified by HEDIS. The map must be complete and accurate.</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed care organization. See definition of health plan above.</td>
</tr>
<tr>
<td>measurement year</td>
<td>The year that the health plan is evaluating through P4P measures, often referred to as the data year. The measurement year is also the year prior to the P4P reporting year; for example, P4P reporting year 2007 is based on measurement year 2006.</td>
</tr>
<tr>
<td>member</td>
<td>An individual (and eligible dependents) who participates in a health plan and who with other participants compose a health plan’s enrolled population. Members usually receive specified health care services from a defined network for a specified time period. For POs this refers to members who are assigned to a provider contracting with or working for the PO for a specified period of time.</td>
</tr>
<tr>
<td>nonstandard code</td>
<td>A code not used or recognized by the majority of practitioners and facilities (see industry standard code and homegrown code). These plan-specific codes must be mapped to industry codes for inclusion in HEDIS.</td>
</tr>
<tr>
<td>PHI</td>
<td>Protected health information. Information that can identify a specific person. Person-identified information is associated with names, social security numbers, alphanumeric codes or other unique individual information.</td>
</tr>
<tr>
<td>PO</td>
<td>Physician organization. Independent Practice Associations (IPA) or medical groups that contract with individual doctors to provide health care services. POs accept risk and manage the business of contracting and compliance with health plans on behalf of the PO’s individual providers.</td>
</tr>
<tr>
<td>POS</td>
<td>Point of service. A HMO with an opt-out option that is accountable for financing and delivering a broad range of comprehensive health services to an enrolled population.</td>
</tr>
<tr>
<td>positive numerator event</td>
<td>Evidence of one measure-required service/event/diagnosis.</td>
</tr>
</tbody>
</table>
**positive numerator hit** | A member who satisfies the numerator requirements of a measure and who may be counted in the numerator. Some measures have multiple numerator requirements; for example, in the Childhood Immunization Status measure, the DTP/DTaP numerator requires four separate immunizations for a member to be a positive numerator hit.

**practitioner** | A professional who provides health care services. Practitioners are usually required to be licensed as defined by law.

**product** | An organized health care system that is accountable for financing and delivering a broad range of comprehensive health services to an enrolled population (HMO, POS, PPO).

**product line** | Commercial, Medicaid, Medicare.

**provider** | An institution or organization that provides medical services to patients. Examples of providers include hospitals and home health agencies.

NCQA uses the term **practitioner** to refer to professionals who provide health care services; however, it recognizes that a **provider directory** generally includes both providers and practitioners, and that the inclusive definition is the more common usage of the **provider**.

**reporting year** | The year in which HEDIS/P4P is reported and for which the volume is named. The year immediately following the measurement year.

**required benefit** | P4P measures evaluate performance and hold plans accountable for services provided in their members’ benefits package. Measure specifications include benefits or coverage categories (e.g., medical, pharmacy, mental health) that are required during the continuous enrollment period.

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