Colorado Medicaid
Managed Care Program

FY 2012–2013 Physical Health Performance Measure Validation Aggregate Report

October 2013

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Introduction

The Colorado State Medicaid agency, the Department of Health Care Policy and Financing (the Department) requires three mandatory external quality review (EQR) activities as per the Balanced Budget Act of 1997 (BBA), 42 Code of Federal Regulations (CFR) 438.358. One of these activities is the validation of performance measures. The Department has contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to conduct the validation of performance measures for two managed care organizations (MCOs)—Denver Health Medicaid Choice (DHMC) and Rocky Mountain Health Plans (RMHP)—and for the Department's Medicaid Fee-for-Service (FFS) and Primary Care Physician Program (PCPP) for fiscal year (FY) 2012–2013.

The Department opted to use selected National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1,2] measures as the performance measures and calendar year 2012 as the measurement period for validation. Developed and maintained by NCQA, HEDIS is a set of performance data broadly accepted in the managed care environment as an industry standard. Because the MCOs and the Department had calculated and submitted HEDIS performance measures and underwent an NCQA HEDIS Compliance Audit™,[3,4] HSAG validated the results from the audits to meet the BBA requirements. More specifically, HSAG's role in the validation of performance measures was to ensure that the validation activities were conducted as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.

The primary objectives of the performance measure validation process were to:

◆ Evaluate the accuracy of the performance measure data collected by the MCOs and the Department for its FFS/PCPP populations.

◆ Determine the extent to which the specific performance measures calculated by the MCOs and the Department followed the specifications established for each performance measure.

Each MCO underwent an NCQA HEDIS Compliance Audit through an NCQA-licensed audit organization of its choice and submitted the audited results and audit statement to HSAG. The Department also underwent an NCQA HEDIS Compliance Audit for its FFS/PCPP populations, which was conducted by HSAG. Since the audits were conducted in compliance with NCQA's *2013*

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

[2] HEDIS formerly stood for Health Plan Employer Data and Information Set.

[3] NCQA HEDIS Compliance Audit™ is a trademark of NCQA. The purpose of conducting a HEDIS audit is to ensure that rates submitted by the MCOs and the Department are reliable, valid, accurate, and can be compared to one another. For a brief overview of the NCQA HEDIS Compliance Audit, please refer to Appendix A.

[4] Although the Department contracted with HSAG to calculate the performance measure results for its FFS/PCPP program and HSAG subcontracted QMark, Inc. (an NCQA-Certified software vendor) to calculate and report the HEDIS measures, the Department, and not its contracted vendors, is ultimately responsible for the HEDIS performance measure results.

HEDIS Compliance Audit: Standards, Policies, and Procedures, *Volume 5,* and the NCQA HEDIS Compliance Audit is consistent with the CMS Performance Measure Validation Protocol, the findings and results from the HEDIS Compliance Audits can be reviewed, validated, and eventually accepted as findings for the validation of performance measures to meet the BBA requirements.

Performance Measure List

The NCQA-licensed audit organizations validated, at a minimum, a set of performance measures selected by the Department. The measures, which are listed in Table 1, are HEDIS measures that follow the definitions outlined in NCQA's *HEDIS 2013 Technical Specifications, Volume 2,* and the reporting method required by the Department.

Table 1—Colorado Medicaid 2013 Performance Measure Reporting Set	
Performance Measures	**Reporting Methodology**
Childhood Immunization Status (Combos 2–10)	Administrative
Immunizations for Adolescents	Administrative
Well-Child Visits in the First 15 Months of Life	Hybrid
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Hybrid
Adolescent Well-Care Visits	Hybrid
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Hybrid
Children's and Adolescents' Access to Primary Care Practitioners	Administrative
Prenatal and Postpartum Care	Hybrid
Adults' Access to Preventive/Ambulatory Health Services	Administrative
Controlling High Blood Pressure	Hybrid
Comprehensive Diabetes Care (excluding HbA1c <7 indicator)	Hybrid
Annual Monitoring for Patients on Persistent Medications	Administrative
Asthma Medication Ratio (FFS/PCPP Populations Only)	Administrative
Chlamydia Screening in Women	Administrative
Adult BMI Assessment	Hybrid
Breast Cancer Screening	Administrative
Cervical Cancer Screening	Administrative
Appropriate Testing for Children with Pharyngitis	Administrative
Anti-depressant Medication Management	Administrative

Table 1—Colorado Medicaid 2013 Performance Measure Reporting Set	
Performance Measures	**Reporting Methodology**
Adherence to Antipsychotics for Individuals with Schizophrenia (FFS/PCPP Populations Only)	Administrative
Follow-up After Hospitalization for Mental Illness (FFS/PCPP Populations Only)	Administrative
Follow-up Care for Children Prescribed ADHD Medication	Administrative
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Administrative
Ambulatory Care: Emergency Department Visits	Administrative
Frequency of Selected Procedures (FFS/PCPP Populations Only)	Administrative

Technical Methods of Analysis

The CMS Performance Measure Validation Protocol identifies key types of data that should be reviewed. As part of the validation process, HSAG aggregated several sources of HEDIS-related data to determine if the licensed organizations' audit process met CMS requirements.

This performance measure validation report uses two primary sources—NCQA's Interactive Data Submission System (IDSS) data output reports and the final audit reports—to tabulate overall HEDIS reporting capabilities and functions for the MCOs and the Department. The IDSS contained the final HEDIS rates that were verified, reviewed, and locked by the licensed organizations. The auditor-locking mechanism in the IDSS tool ensured that no information could be changed without the consent of NCQA and the auditor. The IDSS review process allowed the licensed organizations to assess the reasonability of the rates submitted by the MCOs and the Department.

The following is a table identifying the key audit steps required by NCQA for the Licensed Organization (LO) to conduct HEDIS Compliance Audits. The table also lists HSAG's approach in validating the LO's audit.

Table 2—Description of Data Sources Reviewed	
Key Steps According to NCQA's HEDIS Compliance Audit	**HSAG's Approach on Validating the LO's Audit Results**
Pre-on-site Visit/Meeting—The initial conference call or meeting between the licensed organizations and the MCO or Department staff.	HSAG verified that key HEDIS topics such as timelines and on-site review dates were addressed by the licensed organizations.
Roadmap Review—This review provided the licensed organizations with background information on policies, processes, and data in preparation for on-site validation activities. The MCOs and the Department were required to complete the Roadmap to provide the audit team with the necessary information to begin review activities.[5]	HSAG looked for evidence in the final report that the licensed organizations completed a thorough review of all components of the Roadmap.
Certified Software/Source Code Review—Source code review is used to determine compliance with the performance measure definitions, including accurate numerator and denominator identification, sampling, and algorithmic compliance (to determine if rate calculations were performed correctly, medical record and administrative data were combined appropriately, and numerator events were counted accurately). This process is not necessary if NCQA-Certified software is used.	If an NCQA-Certified software vendor was used, HSAG used the final audit report (FAR) and Software Certification Letter to assess whether or not the software vendor was certified for the measures required by the Department. HSAG ensured that the licensed organizations reviewed the programming language for calculating the HEDIS measures if an NCQA-Certified software vendor was not used.
Consumer Assessment of Healthcare Providers and Systems (**CAHPS**®) **Survey Vendor and Sample Frame Validation**—A certified survey vendor must be used if the MCOs or the Department performed a CAHPS survey as part of HEDIS reporting.[6]	HSAG verified that the licensed organization performed detailed validations on the CAHPS Sample Frame if the MCO and the Department performed a CAHPS survey as part of HEDIS reporting. If the MCO and the Department used a survey vendor to perform the CAHPS surveys, HSAG verified that an NCQA-Certified survey vendor was used.
Primary Source Verification—This verification is performed to determine the validity of the source data used to generate the HEDIS rates. Auditors verify that the information from the primary source matches the output information used for HEDIS reporting. Auditors do this by tracing the movement of the data from the originating source to the HEDIS repository.	HSAG verified that the licensed organizations used this methodology as part of their on-site audit process.

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[5] If the MCOs or the Department contracted certain data calculation, abstraction, or reporting functions to other vendors, they are responsible for ensuring that these vendors completed specific sections of the Roadmap such that the LOs have sufficient information to evaluate all the relevant systems and processes associated with HEDIS reporting.

[6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Table 2—Description of Data Sources Reviewed	
Key Steps According to NCQA's HEDIS Compliance Audit	**HSAG's Approach on Validating the LO's Audit Results**
Convenience Sample Validation—The auditor reviews a small number of processed medical records to uncover potential problems in the process that may require corrective action early in the medical record review (MRR) process. A convenience sample must be prepared unless the auditor determines that a health plan is exempt. NCQA allows organizations to be exempt from the convenience sample if they participated in a HEDIS audit the previous year and passed MRR validation, and if the current MRR process has not changed significantly from the previous year and the organization does not report hybrid measures that the auditor determines to be at risk of inaccurate reporting.	HSAG verified that the licensed organizations determined whether or not the MCOs and the Department were required to undergo a convenience sample validation. HSAG also verified that if a convenience sample validation was not required by a licensed organization, the specific reasons were documented.
Medical Record Review—The licensed organizations are required to perform a more extensive validation of medical records reviewed, which is conducted late in the abstraction process. This validation ensures that the review process was executed as planned and that the results are accurate.	HSAG reviewed whether or not the licensed organizations performed a review of the medical record review processes used by the MCOs and the Department for collecting medical record data for their hybrid measures. HSAG also examined whether the licensed organizations had conducted a re-review of a random sample of medical records for each applicable measure group based on NCQA's protocol.
IDSS Review—The MCOs and the Department are required to complete NCQA's IDSS for the submission of audited rates to NCQA. The auditor finalizes the IDSS by completing the audit review and entering an audit result. This process verifies that the auditor validated all activities that culminated in a rate by the MCOs or the Department. The auditor locks the IDSS so that no information can be changed.	HSAG verified that the licensed organizations completed the IDSS review process.

Validation Findings of Audit Process

Table 3 identifies the key elements used by the LO while conducting its HEDIS 2013 Compliance Audit. These key elements were reviewed by HSAG during validation activities. As presented in Table 3, a checkmark indicates that the licensed organization reviewed the HEDIS activities, which confirmed that HEDIS methodology was being followed. Some activities are identified as being compliant by inserting the name of the company the MCO or the Department contracted with to perform the required tasks.

Table 3—Validation Activities			
	DHMC	**RMHP**	**The Department**
Licensed Organization	HealthcareData Company, LLC	Dunwoody Technology Services Group, LLC (DTS Group)	Health Services Advisory Group, Inc. (HSAG)
Pre-on-site Visit Call/Meeting	✓	✓	✓
Roadmap Review	✓	✓	✓
Software Vendor	Verisk Health, Inc.	Inovalon, Inc.	QMark, Inc.
Source Code/Certified Software Review	✓	✓	✓
Survey Vendor	Morpace Inc.	The Center for the Study of Services	HSAG
CAHPS Sample Frame Validation	✓	✓	✓
Primary Source Verification	✓	✓	✓
Medical Record Review	✓	✓	✓
IDSS Review	✓	✓	✓

Table 3 indicates that the audit conducted for the MCOs and the Department included all of the listed validation activities. The MCOs and the Department used an NCQA-licensed organization to perform their HEDIS audits. In addition, both MCOs and the Department used an NCQA-Certified software vendor for calculating rates; therefore, no source code review was performed. Both the MCOs and the Department also used an NCQA-Certified HEDIS survey vendor to administer the CAHPS survey(s). HSAG also determined that the data collected and reported for the Department-selected measures followed NCQA HEDIS methodology. Therefore, any rates and audit results are determined to be valid, reliable, and accurate.

Compliance With IS Standards

In addition to ensuring that data were captured, reported, and presented in a uniform manner, HSAG evaluated each MCO's and the Department's information system (IS) capabilities for accurate HEDIS reporting. HSAG reviewed the IS capabilities assessments of the MCOs and the Department, which were conducted by licensed organizations and included in the final audit reports. The review specifically focused on those system aspects that could have impacted the reporting of the selected HEDIS Medicaid measures. For the purpose of HEDIS compliance auditing, the terms "information system" or "IS" are used broadly to include the computer and software environment, data collection procedures, and abstraction of medical records for hybrid measures. The IS evaluation includes a review of any manual processes that may have been used for HEDIS reporting as well. The LO determined if the MCOs and the Department had the automated systems, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

In accordance with NCQA's *2013 HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*, the LO evaluated IS compliance with NCQA's IS standards. These standards detail the minimum requirements the MCOs' and the Department's IS systems should meet, as well as criteria that any manual processes used to report HEDIS information must meet. For circumstances in which a particular IS standard was not met, the LO rated the impact on HEDIS reporting capabilities and, particularly, any measure that could be impacted. The MCOs or the Department may not be fully compliant with many of the IS standards but may still be able to report the selected measures.

In general, each MCO's and the Department's information systems and processes were adequate to meet the IS standards and the HEDIS determination reporting requirements. Where only substantial compliance to these standards was identified, the impact was not significant enough to impact the rates.

The section that follows provides a summary of the MCOs' and the Department's key findings for each IS standard as noted in its final audit report. A more in-depth explanation of NCQA's IS standards is provided in Appendix A of this report.

Table 4—Summary of Compliance With IS Standards	
NCQA's IS Standards	**IS Standards Compliance Findings Based on HEDIS 2013 FAR Review**
IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry ♦ Industry standard codes are required and captured. ♦ Primary and secondary diagnosis codes are identified. ♦ Nonstandard codes (if used) are mapped to industry standard codes. ♦ Standard submission forms are used. ♦ Timely and accurate data entry processes and sufficient edit checks are used. ♦ Data completeness is continually assessed and all contracted vendors involved in medical claims processing are monitored.	The Colorado Medicaid MCOs were fully compliant with IS 1.0. The Department was found to be substantially compliant with this standard with minimal impact on HEDIS reporting. This audit finding was due to data completeness issues associated with diagnoses and procedure details for services provided by Federally Qualified Health Centers and Rural Health Centers as a result of the current processing logic of the Medicaid Management Information System (MMIS). The auditor indicated in the FAR that the Department submitted a Customer Service Request to modify the processing logic and is still awaiting a solution. Nonetheless, the issue identified only had minimal impact on the measure reporting.
IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry ♦ All HEDIS-relevant information for data entry or electronic transmissions of enrollment data is accurate and complete. ♦ Manual entry of enrollment data is timely and accurate, and sufficient edit checks are in place. ♦ The health plans continually assess data completeness and take steps to improve performance. ♦ The health plans effectively monitor the quality and accuracy of electronic submissions. ♦ The health plans have effective control processes for the transmission of enrollment data.	The Colorado Medicaid health plans and the Department were fully compliant with IS 2.0. No issues or concerns were noted for this standard relevant to the selected Colorado Medicaid measures.
IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry ♦ Provider specialties are fully documented and mapped to HEDIS provider specialties. ♦ Effective procedures for submitting HEDIS-relevant information are in place. ♦ Electronic transmissions of practitioner data are checked to ensure accuracy. ♦ Processes and edit checks ensure accurate and timely entry of data into the transaction files. ♦ Data completeness is assessed and steps are taken to improve performance. ♦ Vendors are regularly monitored against expected performance standards.	The Colorado Medicaid health plans and the Department were fully compliant with IS 3.0. No issues or concerns were noted for this standard relevant to the selected Colorado Medicaid measures.

Table 4—Summary of Compliance With IS Standards	
NCQA's IS Standards	**IS Standards Compliance Findings Based on HEDIS 2013 FAR Review**
IS 4.0—Medical Record Review Processes— Training, Sampling, Abstraction, and Oversight ◆ Forms or tools used for medical record review capture all fields relevant to HEDIS reporting. ◆ Checking procedures are in place to ensure data integrity for electronic transmission of information. ◆ Retrieval and abstraction of data from medical records are accurately performed. ◆ Data entry processes, including edit checks, are timely and accurate. ◆ Data completeness is assessed, including steps to improve performance. ◆ Vendor performance is monitored against expected performance standards.	The Colorado Medicaid health plans and the Department were fully compliant with IS 4.0. No issues or concerns were noted for this standard relevant to the selected Colorado Medicaid measures.
IS 5.0—Supplemental Data—Capture, Transfer, and Entry ◆ Nonstandard coding schemes are fully documented and mapped to industry standard codes. ◆ Effective procedures for submitting HEDIS-relevant information are in place. ◆ Electronic transmissions of supplemental data are checked to ensure accuracy. ◆ Data entry processes, including edit checks, are timely and accurate. ◆ Data completeness is assessed, including steps to improve performance. ◆ Vendor performance is monitored against expected performance standards.	The Colorado Medicaid health plans and the Department were fully compliant with IS 5.0. No issues or concerns were noted for this standard relevant to the selected Colorado Medicaid measures.
IS 6.0—Member Call Center Data—Capture, Transfer, and Entry	This standard was not applicable to the measures under the scope of the audit.
IS 7.0—Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity ◆ Nonstandard coding schemes are fully documented and mapped to industry standard codes. ◆ Data transfers to the HEDIS repository from transaction files are accurate. ◆ File consolidations, extracts, and derivations are accurate. ◆ The repository structure and formatting are	The Colorado Medicaid health plans and the Department were fully compliant with IS 7.0. No issues or concerns were noted for this standard relevant to the selected Colorado Medicaid measures.

Table 4—Summary of Compliance With IS Standards	
NCQA's IS Standards	**IS Standards Compliance Findings Based on HEDIS 2013 FAR Review**
suitable for HEDIS measures and enable required programming efforts. ◆ Report production is managed effectively and operators perform appropriately. ◆ HEDIS reporting software is managed properly. ◆ Physical control procedures ensure HEDIS data integrity.	

Overview of the HEDIS Compliance Audit

Developed and maintained by NCQA, HEDIS is a set of performance data broadly accepted in the managed care environment as an industry standard. Organizations seeking NCQA accreditation or wishing to publicly report their HEDIS performance results undergo an NCQA HEDIS Compliance Audit through an NCQA-licensed audit organization. The audits are conducted in compliance with NCQA's *2013 HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. The purpose of conducting a HEDIS audit is to ensure that rates submitted by the organizations are reliable, valid, accurate, and can be compared to one another.

During the HEDIS audit, data management processes were reviewed using findings from the NCQA HEDIS Record of Administration, Data Management, and Processes (Roadmap) review; interviews with key staff members; and a review of queries and output files. Data extractions from systems used to house production files and generate reports were reviewed, including a review of data included in the samples for the selected measures. Based on validation findings, the licensed organizations produced an initial written report identifying any perceived issues of noncompliance, problematic measures, and recommended opportunities for improvement. The licensed organizations also produced a final report with updated text and findings based on comments on the initial report.

The FAR included information on the organization's information system (IS) capabilities; each measure's reportable results; medical record review (MRR) validation results; the results of any corrected programming logic, including corrections made to numerators, denominators, or sampling used for final measure calculation; and opportunities and recommendations for improvement of data completeness, data integrity, and health outcomes.

Information Systems Standards

Listed below are the Information Systems Standards published in NCQA's *2013 HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*.

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

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

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

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

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

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

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

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

Rationale

The organization must capture all clinical information pertinent to the delivery of services to provide a basis for calculating measures. The audit process ensures that the organization consistently captures sufficient clinical information. Principal among these practices and critical for computing clinical measures is consistent use of standardized codes to describe medical events, including nationally recognized schemes to capture diagnosis, procedure, DRG, and DSM codes. Standardized coding improves the comparability of measures through common definition of identical clinical events. The organization must cross-reference nonstandard coding schemes at the specific diagnosis and service level to attain equivalent meaning. The integrity of measures requires using standard forms, controlling receipt processes, editing and verifying data entry, and implementing other control procedures that promote completeness and accuracy in receiving and recording medical information. The transfer of information from medical charts to the organizations' databases should be subject to the same standards for accuracy and completeness.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

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

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

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

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

Rationale

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 measures. Specific member information includes age, gender, benefits, product line (commercial, Medicaid, and Medicare), and the dates that define periods of membership so gaps in enrollment can be determined.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

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

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

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

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

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

Rationale

Controlling receipt processes, editing and verifying data entry, and implementing other control procedures to promote completeness and accuracy in receiving and recording provider information are critical in databases that calculate measures. Specific provider information includes the provider's specialty, contracts, credentials, populations served, date of inclusion in the network, date of credentialing, board certification status, and information needed to develop medical record abstraction tools.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

IS 4.1 Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off).

IS 4.2 Retrieval and abstraction of data from medical records are reliably and accurately performed.

IS 4.3 Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.

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

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

Rationale

Medical record review validation ensures that record abstraction performed by or on behalf of the entity meets standards for sound processes and that abstracted data are accurate. Validation includes not only an over-read of abstracted medical records, but also a review of medical record review tools, policies, and procedures related to data entry and transfer, and training materials developed by or on behalf of the entity.

IS 5.0—Supplemental Data—Capture, Transfer, and Entry

IS 5.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes.

IS 5.2 The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of data have checking procedures to ensure accuracy.

IS 5.3 Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.

IS 5.4 The organization continually assesses data completeness and takes steps to improve performance.

IS 5.5 The organization regularly monitors vendor performance against expected performance standards.

Rationale

Organizations may use a supplemental database to collect and store data, which is then used to augment rates. These databases must be scrutinized closely since they can be internal or external, and standard versus nonstandard. The auditor must determine whether sufficient control processes are in place related to data collection, validation of data entry into the database, and use of these data. Mapping documents and file layouts may be reviewed as well, to determine compliance with this standard.

IS 6.0—Member Call Center Data—Capture, Transfer, and Entry*

IS 6.1 Member call center data are reliably and accurately captured.

*This standard was not applicable to the measures under the scope of the audit.

IS 7.0—Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

IS 7.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes.

IS 7.2 Data transfers to repository from transaction files are accurate.

IS 7.3 File consolidations, extracts, and derivations are accurate.

IS 7.4 The repository structure and formatting are suitable for measures and enable required programming efforts.

IS 7.5 Report production is managed effectively and operators perform appropriately.

IS 7.6 Measure reporting software is managed properly with regard to development, methodology, documentation, revision control, and testing.

IS 7.7 Physical control procedures ensure measure data integrity such as physical security, data access authorization, disaster recovery facilities, and fire protection.

Rationale

Calculating rates requires data from multiple sources. The systems used to assemble the data and to make the required calculations should be carefully constructed and tested. The organization's quality assurance practices and backup procedures serve as an organizational infrastructure supporting all information systems. The practices and procedures promote accurate and timely information processing and data protection in the event of a disaster. Data needed to calculate measures are produced by the organization's information systems and may be directly or indirectly affected by IS practices and procedures.

Table B-1—HEDIS Audit Results		
Audit Finding	**Description**	**Audit Result**
For HEDIS Measures		
The rate or numeric result for a HEDIS measure is reportable. The measure was fully or substantially compliant with HEDIS specifications or had only minor deviations that did not significantly bias the reported rate.	Reportable	*R*
HEDIS specifications were followed but the denominator was too small to report a valid rate.	Denominator <30	*NA*
The health plan did not offer the health benefits required by the measure.	No Benefit (Benefit Not Offered)	*NB*
1. The health plan calculated the measure but the rate was materially biased, or 2. The health plan chose not to report the measure.	Not Reportable	*NR*

Table B-2—DHMC's Rates and Audit Results		
HEDIS Measure	**2013 HEDIS Rate**	**Audit Result**
Childhood Immunization Status		
DTaP	81.29%	*R*
IPV	90.01%	*R*
MMR	90.01%	*R*
HiB	89.52%	*R*
Hepatitis B	92.33%	*R*
VZV	89.87%	*R*
Pneumococcal Conjugate	84.18%	*R*
Hepatitis A	89.38%	*R*
Rotavirus	68.21%	*R*
Influenza	74.05%	*R*
Combination #2	81.22%	*R*
Combination #3	80.87%	*R*
Combination #4	80.73%	*R*
Combination #5	65.75%	*R*
Combination #6	69.76%	*R*
Combination #7	65.61%	*R*
Combination #8	69.69%	*R*
Combination #9	56.96%	*R*
Combination #10	56.89%	*R*
Immunizations for Adolescents		
Meningococcal	80.17%	*R*
Tdap/Td	81.75%	*R*
Combination 1	79.54%	*R*
Well-Child Visits in the First 15 Months of Life		
0 Visits	1.22%	*R*
6+ Visits	69.10%	*R*
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.91%	*R*
Adolescent Well-Care Visits	49.15%	*R*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile (3–11 Years)	88.08%	*R*
BMI Percentile (12–17 Years)	87.16%	*R*
BMI Percentile (Total)	87.83%	*R*
Counseling for Nutrition (3–11 Years)	75.83%	*R*
Counseling for Nutrition (12–17 Years)	73.39%	*R*
Counseling for Nutrition (Total)	75.18%	*R*
Counseling for Physical Activity (3–11 Years)	54.97%	*R*
Counseling for Physical Activity (12–17 Years)	67.89%	*R*
Counseling for Physical Activity (Total)	58.39%	*R*

Table B-2—DHMC's Rates and Audit Results		
HEDIS Measure	**2013 HEDIS Rate**	**Audit Result**
Children's and Adolescents' Access to Primary Care Practitioners		
12–24 Months	92.28%	*R*
25 Months–6 Years	78.88%	*R*
7–11 Years	83.64%	*R*
12–19 Years	85.82%	*R*
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	85.40%	*R*
Postpartum Care	54.99%	*R*
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	66.48%	*R*
45–64 Years	75.42%	*R*
65+ Years	71.30%	*R*
Total	70.11%	*R*
Controlling High Blood Pressure	70.07%	*R*
Comprehensive Diabetes Care		
HbA1c Testing	83.21%	*R*
HbA1c Poor Control (>9.0%)	33.58%	*R*
HbA1c Control (<8.0%)	51.09%	*R*
Eye Exam	50.12%	*R*
LDL-C Screening	70.32%	*R*
LDL-C Level <100 mg/dL	50.36%	*R*
Medical Attention for Nephropathy	80.78%	*R*
Blood Pressure Controlled <140/80 mm Hg	50.61%	*R*
Blood Pressure Controlled <140/90 mm Hg	70.07%	*R*
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	87.44%	*R*
Digoxin	NA	*R*
Diuretics	86.68%	*R*
Anticonvulsants	60.81%	*R*
Total	84.14%	*R*
Asthma Medication Ratio (Voluntary)		
5–11 Years	52.32%	*R*
12–18 Years	53.78%	*R*
19–50 Years	27.40%	*R*
51–64 Years	37.14%	*R*
Total	44.41%	*R*
Chlamydia Screening in Women		
16–20 Years	71.26%	*R*
21–24 Years	73.53%	*R*
Total	72.35%	*R*

Table B-2—DHMC's Rates and Audit Results		
HEDIS Measure	**2013 HEDIS Rate**	**Audit Result**
Adult BMI Assessment	86.86%	*R*
Breast Cancer Screening	49.16%	*R*
Cervical Cancer Screening	51.13%	*R*
Appropriate Testing for Children with Pharyngitis	70.30%	*R*
Anti-depressant Medication Management		
Effective Acute Phase Treatment	57.14%	*R*
Effective Continuation Phase Treatment	45.05%	*R*
Follow-up Care for Children Prescribed ADHD Medication		
Initiation Phase	24.55%	*R*
Continuation and Maintenance Phase	NA	*R*
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment (13–17 Years)	33.90%	*R*
Engagement of AOD Treatment (13–17 Years)	1.69%	*R*
Initiation of AOD Treatment (18+ Years)	48.21%	*R*
Engagement of AOD Treatment (18+ Years)	3.44%	*R*
Initiation of AOD Treatment (Total)	47.14%	*R*
Engagement of AOD Treatment (Total)	3.31%	*R*
Ambulatory Care		
ED Visits per 1,000 MM	44.56	*R*

Table B-3—RMHP's Rates and Audit Results		
HEDIS Measure	**2013 HEDIS Rate**	**Audit Result**
Childhood Immunization Status		
DTaP	85.42%	**R**
IPV	94.68%	**R**
MMR	92.36%	**R**
HiB	95.83%	**R**
Hepatitis B	91.44%	**R**
VZV	91.20%	**R**
Pneumococcal Conjugate	86.34%	**R**
Hepatitis A	13.19%	**R**
Rotavirus	73.38%	**R**
Influenza	55.56%	**R**
Combination #2	78.24%	**R**
Combination #3	76.16%	**R**
Combination #4	12.73%	**R**
Combination #5	63.43%	**R**
Combination #6	52.08%	**R**
Combination #7	11.34%	**R**
Combination #8	9.03%	**R**
Combination #9	44.91%	**R**
Combination #10	8.10%	**R**
Immunizations for Adolescents		
Meningococcal	57.32%	**R**
Tdap/Td	81.57%	**R**
Combination 1	53.79%	**R**
Well-Child Visits in the First 15 Months of Life		
0 Visits	0.23%	**R**
6+ Visits	82.64%	**R**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.75%	**R**
Adolescent Well-Care Visits	42.82%	**R**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile (3–11 Years)	74.60%	**R**
BMI Percentile (12–17 Years)	67.94%	**R**
BMI Percentile (Total)	72.65%	**R**
Counseling for Nutrition (3–11 Years)	66.67%	**R**
Counseling for Nutrition (12–17 Years)	55.73%	**R**
Counseling for Nutrition (Total)	63.45%	**R**
Counseling for Physical Activity (3–11 Years)	57.78%	**R**
Counseling for Physical Activity (12–17 Years)	54.20%	**R**
Counseling for Physical Activity (Total)	56.73%	**R**

Table B-3—RMHP's Rates and Audit Results		
HEDIS Measure	2013 HEDIS Rate	Audit Result
Children's and Adolescents' Access to Primary Care Practitioners		
12–24 Months	96.90%	*R*
25 Months–6 Years	87.14%	*R*
7–11 Years	90.90%	*R*
12–19 Years	89.99%	*R*
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	95.64%	*R*
Postpartum Care	73.83%	*R*
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	85.71%	*R*
45–64 Years	91.62%	*R*
65+ Years	96.54%	*R*
Total	88.81%	*R*
Controlling High Blood Pressure	73.38%	*R*
Comprehensive Diabetes Care		
HbA1c Testing	92.20%	*R*
HbA1c Poor Control (>9.0%)	19.24%	*R*
HbA1c Control (<8.0%)	72.23%	*R*
Eye Exam	62.73%	*R*
LDL-C Screening	75.55%	*R*
LDL-C Level <100 mg/dL	44.86%	*R*
Medical Attention for Nephropathy	76.22%	*R*
Blood Pressure Controlled <140/80 mm Hg	61.52%	*R*
Blood Pressure Controlled <140/90 mm Hg	79.85%	*R*
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	86.67%	*R*
Digoxin	NA	*NA*
Diuretics	91.78%	*R*
Anticonvulsants	75.76%	*R*
Total	86.03%	*R*
Asthma Medication Ratio (Voluntary)		
5–11 Years	55.43%	*R*
12–18 Years	53.25%	*R*
19–50 Years	48.05%	*R*
51–64 Years	NA	*NA*
Total	52.27%	*R*
Chlamydia Screening in Women		
16–20 Years	44.31%	*R*
21–24 Years	47.55%	*R*
Total	46.15%	*R*

Table B-3—RMHP's Rates and Audit Results		
HEDIS Measure	2013 HEDIS Rate	Audit Result
Adult BMI Assessment	80.26%	*R*
Breast Cancer Screening	47.79%	*R*
*Cervical Cancer Screening**	68.48%	*R*
Appropriate Testing for Children with Pharyngitis	89.90%	*R*
Anti-depressant Medication Management		
Effective Acute Phase Treatment	NB	*NB*
Effective Continuation Phase Treatment	NB	*NB*
Follow-up Care for Children Prescribed ADHD Medication		
Initiation Phase	43.56%	*R*
Continuation and Maintenance Phase	40.63%	*R*
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment (13–17 Years)	NB	*NB*
Engagement of AOD Treatment (13–17 Years)	NB	*NB*
Initiation of AOD Treatment (18+ Years)	NB	*NB*
Engagement of AOD Treatment (18+ Years)	NB	*NB*
Initiation of AOD Treatment (Total)	NB	*NB*
Engagement of AOD Treatment (Total)	NB	*NB*
Ambulatory Care		
ED Visits per 1,000 MM	62.73	*R*
*Values shown are audited rates in the IDSS using a hybrid data collection methodology rather than an administration data collection methodology as required by the Department.		

Table B-4—FFS/PCPP's Rates and Audit Results Reported by the Department				
	PCPP		FFS	
HEDIS Measure	**2013 HEDIS Rate**	**Audit Result**	**2013 HEDIS Rate**	**Audit Result**
Childhood Immunization Status				
DTaP	77.73%	*R*	65.47%	*R*
IPV	92.34%	*R*	81.77%	*R*
MMR	91.88%	*R*	81.02%	*R*
HiB	93.27%	*R*	82.36%	*R*
Hepatitis B	91.88%	*R*	81.17%	*R*
VZV	91.88%	*R*	81.04%	*R*
Pneumococcal Conjugate	85.38%	*R*	66.79%	*R*
Hepatitis A	92.34%	*R*	68.10%	*R*
Rotavirus	67.98%	*R*	55.55%	*R*
Influenza	53.60%	*R*	44.12%	*R*
Combination #2	74.25%	*R*	59.52%	*R*
Combination #3	72.62%	*R*	56.35%	*R*
Combination #4	72.39%	*R*	48.57%	*R*
Combination #5	58.70%	*R*	41.58%	*R*
Combination #6	45.94%	*R*	34.30%	*R*
Combination #7	58.47%	*R*	36.13%	*R*
Combination #8	45.94%	*R*	31.72%	*R*
Combination #9	38.05%	*R*	26.42%	*R*
Combination #10	38.05%	*R*	24.44%	*R*
Immunizations for Adolescents				
Meningococcal	71.06%	*R*	57.32%	*R*
Tdap/Td	86.83%	*R*	75.15%	*R*
Combination 1	70.66%	*R*	55.74%	*R*
Well-Child Visits in the First 15 Months of Life				
0 Visits	2.67%	*R*	1.95%	*R*
6+ Visits	62.00%	*R*	61.31%	*R*
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	61.56%	*R*	60.34%	*R*
Adolescent Well-Care Visits	39.42%	*R*	37.71%	*R*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile (3–11 Years)	77.66%	*R*	53.51%	*R*
BMI Percentile (12–17 Years)	78.26%	*R*	51.43%	*R*
BMI Percentile (Total)	77.86%	*R*	52.80%	*R*
Counseling for Nutrition (3–11 Years)	65.20%	*R*	58.67%	*R*
Counseling for Nutrition (12–17 Years)	54.35%	*R*	51.43%	*R*
Counseling for Nutrition (Total)	61.56%	*R*	56.20%	*R*
Counseling for Physical Activity (3–11 Years)	65.93%	*R*	45.02%	*R*

Table B-4—FFS/PCPP's Rates and Audit Results Reported by the Department				
	PCPP		FFS	
HEDIS Measure	2013 HEDIS Rate	Audit Result	2013 HEDIS Rate	Audit Result
Counseling for Physical Activity (12–17 Years)	60.14%	*R*	55.71%	*R*
Counseling for Physical Activity (Total)	63.99%	*R*	48.66%	*R*
Children's and Adolescents' Access to Primary Care Practitioners				
12–24 Months	97.86%	*R*	94.64%	*R*
25 Months–6 Years	86.55%	*R*	81.85%	*R*
7–11 Years	89.61%	*R*	86.35%	*R*
12–19 Years	88.78%	*R*	86.09%	*R*
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	86.34%	*R*	78.59%	*R*
Postpartum Care	69.67%	*R*	56.69%	*R*
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	82.06%	*R*	75.83%	*R*
45–64 Years	84.62%	*R*	81.63%	*R*
65+ Years	82.83%	*R*	75.03%	*R*
Total	83.02%	*R*	77.00%	*R*
Controlling High Blood Pressure	46.47%	*R*	40.39%	*R*
Comprehensive Diabetes Care				
HbA1c Testing	71.29%	*R*	64.48%	*R*
HbA1c Poor Control (>9.0%)	57.66%	*R*	67.88%	*R*
HbA1c Control (<8.0%)	36.98%	*R*	27.98%	*R*
Eye Exam	50.36%	*R*	40.63%	*R*
LDL-C Screening	57.91%	*R*	53.28%	*R*
LDL-C Level <100 mg/dL	30.66%	*R*	23.60%	*R*
Medical Attention for Nephropathy	66.67%	*R*	69.10%	*R*
Blood Pressure Controlled <140/80 mm Hg	39.66%	*R*	37.47%	*R*
Blood Pressure Controlled <140/90 mm Hg	54.26%	*R*	51.34%	*R*
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	72.51%	*R*	87.20%	*R*
Digoxin	NA	*R*	86.42%	*R*
Diuretics	77.07%	*R*	86.41%	*R*
Anticonvulsants	48.87%	*R*	52.99%	*R*
Total	66.77%	*R*	80.26%	*R*
Asthma Medication Ratio (Voluntary)				
5–11 Years	63.45%	*R*	70.52%	*R*
12–18 Years	64.10%	*R*	60.68%	*R*
19–50 Years	49.50%	*R*	47.05%	*R*
51–64 Years	48.57%	*R*	54.95%	*R*
Total	58.79%	*R*	61.76%	*R*

Table B-4—FFS/PCPP's Rates and Audit Results Reported by the Department				
	PCPP		FFS	
HEDIS Measure	**2013 HEDIS Rate**	**Audit Result**	**2013 HEDIS Rate**	**Audit Result**
Chlamydia Screening in Women				
16–20 Years	27.49%	*R*	48.78%	*R*
21–24 Years	30.28%	*R*	58.74%	*R*
Total	28.75%	*R*	53.96%	*R*
Adult BMI Assessment	71.05%	*R*	71.29%	*R*
Breast Cancer Screening	30.36%	*R*	27.87%	*R*
Cervical Cancer Screening	27.66%	*R*	44.76%	*R*
Appropriate Testing for Children with Pharyngitis	68.16%	*R*	73.51%	*R*
Anti-depressant Medication Management				
Effective Acute Phase Treatment	65.35%	*R*	64.02%	*R*
Effective Continuation Phase Treatment	48.51%	*R*	49.02%	*R*
Adherence to Antipsychotics for Individuals with Schizophrenia	80.68%	*R*	75.40%	*R*
Follow-up After Hospitalization for Mental Illness*				
30-day follow-up	NR	*NR*	NR	*NR*
7-day follow-up	NR	*NR*	NR	*NR*
Follow-up Care for Children Prescribed ADHD Medication				
Initiation Phase	35.96%	*R*	40.15%	*R*
Continuation and Maintenance Phase	30.95%	*R*	45.24%	*R*
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment (13–17 Years)	25.00%	*R*	26.19%	*R*
Engagement of AOD Treatment (13–17 Years)	6.82%	*R*	12.12%	*R*
Initiation of AOD Treatment (18+ Years)	25.99%	*R*	27.80%	*R*
Engagement of AOD Treatment (18+ Years)	2.64%	*R*	5.40%	*R*
Initiation of AOD Treatment (Total)	25.90%	*R*	27.66%	*R*
Engagement of AOD Treatment (Total)	3.01%	*R*	5.98%	*R*
Ambulatory Care				
ED Visits per 1,000 MM	57.84	*R*	67.02	*R*
Frequency of Selected Procedures per 1,000 MM				
Bariatric weight loss surgery, Ages 0–19, Male	0.00	*R*	0.00	*R*
Bariatric weight loss surgery, Ages 0–19, Female	0.00	*R*	0.00	*R*
Bariatric weight loss surgery, Ages 20–44, Male	0.05	*R*	0.03	*R*
Bariatric weight loss surgery, Ages 20–44, Female	0.06	*R*	0.08	*R*
Bariatric weight loss surgery, Ages 45–64, Male	0.00	*R*	0.01	*R*
Bariatric weight loss surgery, Ages 45–64, Female	0.09	*R*	0.11	*R*
Tonsillectomy, Ages 0–9, Male and Female	0.59	*R*	0.60	*R*
Tonsillectomy, Ages 10–19, Male and Female	0.49	*R*	0.44	*R*
Hysterectomy, Abdominal, Ages 15–44, Female	0.10	*R*	0.21	*R*
Hysterectomy, Abdominal, Ages 45–64, Female	0.32	*R*	0.32	*R*

Table B-4—FFS/PCPP's Rates and Audit Results Reported by the Department				
	PCPP		FFS	
HEDIS Measure	**2013 HEDIS Rate**	**Audit Result**	**2013 HEDIS Rate**	**Audit Result**
Hysterectomy, Vaginal, Ages 15–44, Female	0.25	*R*	0.26	*R*
Hysterectomy, Vaginal, Ages 45–64, Female	0.14	*R*	0.27	*R*
Cholecystectomy, Open, Ages 30–64, Male	0.15	*R*	0.06	*R*
Cholecystectomy, Open, Ages 15–44, Female	0.00	*R*	0.02	*R*
Cholecystectomy, Open, Ages 45–64, Female	0.00	*R*	0.07	*R*
Cholecystectomy, Laparoscopic, Ages 30–64, Male	0.40	*R*	0.36	*R*
Cholecystectomy, Laparoscopic, Ages 15–44, Female	0.66	*R*	0.91	*R*
Cholecystectomy, Laparoscopic, Ages 45–64, Female	0.82	*R*	0.68	*R*
Back Surgery, Ages 20–44, Male	0.21	*R*	0.37	*R*
Back Surgery, Ages 20–44, Female	0.24	*R*	0.23	*R*
Back Surgery, Ages 45–64, Male	0.46	*R*	0.80	*R*
Back Surgery, Ages 45–64, Female	0.64	*R*	0.77	*R*
Mastectomy, Ages 15–44, Female	0.00	*R*	0.03	*R*
Mastectomy, Ages 45–64, Female	0.09	*R*	0.32	*R*
Lumpectomy, Ages 15–44, Female	0.12	*R*	0.09	*R*
Lumpectomy, Ages 45–64, Female	0.18	*R*	0.50	*R*

* The Department initially considered reporting this measure for HEDIS 2013 this year using the behavioral health encounter data submitted by contracted behavioral health organizations. However, since it was determined that the Department could not identify the specific provider types for the Federally Qualified Health Centers or the Community Mental Health Centers as prescribed by the HEDIS Technical Specifications to report the FUH measure, the Department chose not to report the measure this year.