COLORADO
Department of Health Care Policy & Financing

FY 2015–2016 Physical Health Performance Measure Validation Aggregate Report

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This report was produced by Health Services Advisory Group, Inc., for the Colorado Department of Health Care Policy & Financing.

HSAG HEALTH SERVICES ADVISORY GROUP

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Validation of Performance Measures

Introduction

The Colorado State Medicaid agency, the Department of Health Care Policy & 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) for fiscal year (FY) 2015–2016.

The Department opted to use selected National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measures as the performance measures and calendar year 2015 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™,[2,3] 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 population.
- 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 population, which was

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] 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.
[3] Although the Department contracted with HSAG to calculate the performance measure results for its FFS program and HSAG subcontracted IMI Health, Inc. (a software vendor whose measures passed NCQA's measure certification process) to calculate and report the HEDIS measures, the Department, and not its contracted vendors, is ultimately responsible for the HEDIS performance measure results.

conducted by HSAG. Since the audits were conducted in compliance with NCQA's *2016 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 NCQA HEDIS Compliance Audit 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 2016 Technical Specifications, Volume 2,* and the reporting method required by the Department.

Table 1—Health First Colorado[4] 2016 Performance Measure Reporting Set

Performance Measures	Reporting Methodology
Childhood Immunization Status	Administrative
Immunizations for Adolescents	Administrative
Well-Child Visits in the First 15 Months of Life	Administrative
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Administrative
Adolescent Well-Care Visits	Administrative
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Hybrid
Appropriate Testing for Children With Pharyngitis	Administrative
Annual Dental Visit	Administrative
Appropriate Treatment for Children With Upper Respiratory Infection	Administrative
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

[4] In Colorado, Medicaid is now known as Health First Colorado (Colorado's Medicaid Program).

Performance Measures	Reporting Methodology
Use of Imaging Studies for Low Back Pain	Administrative
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Administrative
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Administrative
Asthma Medication Ratio	Administrative
Medication Management for People With Asthma	Administrative
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Administrative
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	Administrative
Chlamydia Screening in Women	Administrative
Breast Cancer Screening	Administrative
Cervical Cancer Screening	Hybrid
Non-Recommended Cervical Cancer Screening in Adolescent Females	Administrative
Adult Body Mass Index (BMI) Assessment	Hybrid
Anti-depressant Medication Management	Administrative
Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	Administrative
Ambulatory Care: Emergency Department Visits and Outpatient Visits	Administrative
Inpatient Utilization—General Hospital/Acute Care	Administrative
Antibiotic Utilization	Administrative
Frequency of Selected Procedures	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 LOs.
Roadmap Review—This review provided the LOs 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 LOs completed a thorough review of all components of the Roadmap.
Certified Measures/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 the MCO or the Department contracts with a vendor participating in NCQA's Measure Certification process.	If the MCO or the Department contracted a vendor who participated in NCQA's Measure Certification process, HSAG used the final audit report (FAR) and Measure Certification Report to assess whether or not that vendor was certified for the measures required by the Department. If a vendor not participating in the NCQA's Measure Certification process was contracted, HSAG ensured that the LOs reviewed the programming language developed for the HEDIS measures.
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 LO 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.

[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).

Key Steps According to NCQA's HEDIS Compliance Audit	HSAG's Approach on Validating the LO's Audit Results
Supplemental Data Validation—If the MCOs used any supplemental data for reporting, the LO was to validate the supplemental data according to NCQA's guideline.	HSAG verified whether the LO was following NCQA-required approach while validating the supplemental databases.
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 LOs 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 an LO, the specific reasons were documented.
Medical Record Review—The LOs 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 LOs 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 LOs 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 LOs completed the IDSS review process.

Validation Findings of Audit Process

Table 3 identifies the key elements used by the LO while conducting its HEDIS 2016 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	Attest Health Care Advisors	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.	IMI Health
Source Code/Certified Measure Review	✓	✓	✓
Survey Vendor	Morpace Inc.	Center for the Study of Services (CSS)	Survey sample frame validation was not applicable to the scope of the audit.
CAHPS Sample Frame Validation	✓	✓	Survey sample frame validation was not applicable to the scope of the audit.
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 contracted with vendors to calculate and produce rates, and all of these vendors achieved full measure certification status through NCQA for the reported HEDIS measures. Both the MCOs also used an NCQA-Certified HEDIS survey vendor to administer the CAHPS survey(s), while the Department did not have a CAHPS survey administered for its FFS population. 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 *2016 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.

Based on HSAG's reviews, one MCO's and the Department's information systems and processes were compliant with all IS standards and the HEDIS determination reporting requirements. One MCO received a "substantially met" designation for two IS standards and a "not met" for one. As a result, this MCO was not able to report two measures (*Inpatient Utilization-General Hospital/Acute Care* [IPU] and *Ambulatory Care: Emergency Department Visits and Outpatient Visits* [AMB]) for the current measurement year.

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 the NCQA 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 2014 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 MCOs and the Department were fully compliant with IS Standard 1.0. No issues or concerns relevant to the selected measures were noted for this standard.
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 MCOs and the Department were fully compliant with IS Standard 2.0. The MCOs and the Department had adequate policies and procedures related to enrollment data processing.
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.	The MCOs and the Department were fully compliant with IS Standard 3.0. The MCOs and the Department had adequate policies and procedures related to practitioner data processing.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS 2014 FAR Review
• Vendors are regularly monitored against expected performance standards.	
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 MCOs and the Department were fully compliant with IS Standard 4.0. No issues or concerns relevant to the selected measures were noted for this standard.
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 Department and the MCOs were fully compliant with IS Standard 5.0. No issues or concerns relevant to the selected HEDIS measures were noted. Sufficient policies and procedures were in place related the capture, transfer, and entry of supplemental data.
IS 6.0—Member Call Center Data—Capture, Transfer, and Entry	IS Standard 6.0 was not applicable to the selected HEDIS 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.	The Department and the MCOs were fully compliant with IS Standard 7.0. The auditors identified no notable issues with any negative impact on HEDIS measure results reporting.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS 2014 FAR Review
• Data transfers to the HEDIS repository from transaction files are accurate. • File consolidations, extracts, and derivations are accurate. • The repository structure and formatting are 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. • The organization regularly monitors vendor performance against expected performance standards.	

Appendix A. Information Systems Standards

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 *2016 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 2016 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 standard, nonstandard, or member-reported. 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 (where applicable) and file layouts may be reviewed as well, to determine compliance with this standard. All supplemental databases are validated annually. Proof-of-service verification is required for nonstandard or member-reported data.

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.

IS 7.8 The organization regularly monitors vendor performance against expected performance standards.

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.