COLORADO

Department of Health Care Policy & Financing

MY 2022 HEDIS® Compliance Audit Aggregate Report

October 2023

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), contracts with Health Services Advisory Group, Inc. (HSAG), to perform the three mandatory external quality review (EQR) activities required by the Medicaid managed care regulations released May 6, 2016. Validation of the performance measures calculated and submitted by each managed care organization (MCO) is one of these mandatory activities as articulated in 42 Code of Federal Regulations (CFR) §438.358. The Department contracted with HSAG, an external quality review organization (EQRO), to conduct the validation of performance measures for two MCOs, Denver Health Medical Plan (DHMP) and Rocky Mountain Health Plans Medicaid Prime (RMHP Prime), based on measurement year (MY) 2022 data.

The Department opted to use select National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measures as the performance measures and calendar year 2021 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 calculated and submitted performance measures and underwent an NCQA HEDIS Compliance Audit™[2], HSAG validated the results from the audits to meet the requirements articulated in the Medicaid managed care regulations. 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, *CMS External Quality Review (EQR) Protocols*, *February 2023*.[3]

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

- Evaluate the accuracy of the performance measure data collected by the MCOs.
- Determine the extent to which the specific performance measures calculated by the MCOs 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. Since the audits were conducted in compliance with NCQA's *HEDIS Measurement Year (MY) 2022 Compliance Audit: Standards, Policies, and Procedures*, *Volume 5,* and the NCQA HEDIS Compliance Audit is

[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 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] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Aug 31, 2023.

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 managed care 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 CMS' *Core Set of Adult/Child Health Care Quality Measures for Medicaid Reporting Manual,* and the reporting method required by the Department.

Table 1—Health First Colorado MY 2022 Performance Measure Reporting Set[4]

Performance Measures	Reporting Methodology
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years, *Ages 18 to 64 Years*, and *Ages 65 Years and Older*	Administrative
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	Administrative
Asthma Medication Ratio—Ages 5 to 11 Years, *Ages 12 to 18 Years*, *Ages 19 to 50 Years*, and *Ages 51 to 64 Years*	Administrative
Breast Cancer Screening	Administrative
Controlling High Blood Pressure	Administrative
Contraceptive Care—Postpartum Women—Ages 15 to 20 Years and *Ages 21 to 44 Years*	Administrative
Cervical Cancer Screening	Administrative
Contraceptive Care—All Women—Ages 15 to 20 Years and *Ages 21 to 44 Years*	Administrative
Screening for Depression and Follow-Up Plan—Ages 12 to 17 Years, *Ages 18 to 64 Years*, and *Ages 65 Years and Older*	Administrative
Chlamydia Screening in Women—Ages 16 to 20 Years and *Ages 21 to 24 Years*	Administrative
Concurrent Use of Opioids and Benzodiazepines	Administrative
Colorectal Cancer Screening	Administrative
Follow-Up After Emergency Department Visit for Substance Use—Ages 13 to 17 Years, *Ages 18 to 64 Years*, and *Ages 65 Years and Older*	Administrative

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

Performance Measures	Reporting Methodology
Follow-Up After Hospitalization for Mental Illness—Ages 6 to 17 Years, *Ages 18 to 64 Years*, and *Ages 65 Years* and *Older*	Administrative
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up and *30-Day Follow-Up—Ages 6 to 17 Years*, *Ages 18 to 64 Years*, and *Ages 65 Years and Older*	Administrative
Hemoglobin A1c Control for Patients With Diabetes	Administrative
Diabetes Care for People With Serious Mental Illness—HbA1c Poor Control (>9.0%)	Administrative
HIV Viral Load Suppression	Administrative
Initiation and Engagement of Substance Use Disorder (SUD) Treatment	Administrative
Use of Opioids at High Dosage in Persons Without Cancer	Administrative
Use of Pharmacotherapy for Opioid Use Disorder	Administrative
Plan All-Cause Readmissions	Administrative
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	Administrative
Diabetes Short-Term Complications Admission Rate	Administrative
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	Administrative
Heart Failure Admission Rate	Administrative
Asthma in Younger Adults Admission Rate	Administrative
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Administrative
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Administrative
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Administrative
Ambulatory Care—Emergency Department (ED) Visits	Administrative
Metabolic Monitoring for Children and Adolescents on Antipsychotics	Administrative
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Administrative
Childhood Immunization Status—Combinations 3, *7*, and *10*	Administrative

Performance Measures	Reporting Methodology
Developmental Screening in the First Three Years of Life	Administrative
Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and *Combination 2 (Meningococcal, Tdap, HPV)*	Administrative
Lead Screening in Children	Administrative
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits and *Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*	Administrative
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile, *Counseling for Nutrition*, and *Counseling for Physical Activity*	Administrative
Child and Adolescent Well-Care Visits	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' (LOs') audit processes met CMS requirements.

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

The following is a table identifying the key audit steps required by NCQA for the 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
Initial Visit/Meeting—The initial conference call or meeting between the LOs and the MCO staff.	HSAG verified that key HEDIS topics such as timelines and virtual 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 virtual review validation activities. The MCOs 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 contracts with a	If the MCO used a software vendor to produce HEDIS rates, HSAG used the FAR and measure certification letter to assess whether or not the software vendor achieved full measure certification status by NCQA for the reported HEDIS measures. HSAG ensured that the LOs reviewed the programming language for calculating the HEDIS measures if such a vendor was not used. Please note that the Department required both MCOs to report all HEDIS and non-HEDIS measures; however, they were not required to be audited. Therefore,

[5] If the MCOs 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.

Key Steps According to NCQA's HEDIS Compliance Audit	HSAG's Approach on Validating the LO's Audit Results
vendor participating in the NCQA Measure Certification[6] process.	source code review for the non-HEDIS measures was not conducted by RMHP Prime's LO.
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] Survey Vendor and Sample Frame Validation—A certified survey vendor must be used if the MCOs performed a CAHPS survey as part of HEDIS reporting.	HSAG verified that the LOs performed detailed validations on the CAHPS Sample Frame if the MCOs performed a CAHPS survey as part of HEDIS reporting. If the MCOs used a survey vendor to perform the CAHPS surveys, HSAG verified that an NCQA-Certified survey vendor was used.
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 LOs were following an 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 the MCO 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 did not review this step since the State requires administrative rates only.
Medical Record Review Validation (MRRV)—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 did not review this step since the State requires administrative rates only.
IDSS Review—The MCOs 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. The auditor locks the IDSS so that no information can be changed.	HSAG verified that the LOs completed the IDSS review process.

[6] NCQA Measure Certification℠ is a service mark of the National Committee for Quality Assurance (NCQA).

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

Validation Findings of Audit Process

Table 3 identifies the key elements used by the LOs while conducting their MY 2022 NCQA HEDIS Compliance Audits. These key elements were reviewed by HSAG during validation activities. As presented in Table 3, a checkmark indicates that the LOs 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 contracted with to perform the required tasks.

Table 3—Validation Activities

	DHMP	RMHP Prime
Licensed Organization	Attest Health Care Advisors	DTS Group
Initial Visit Call/Meeting	✓	✓
Roadmap Review	✓	✓
Software Vendor	Cotiviti	Inovalon, Inc.
Source Code/Certified Measure Review	✓	✓
Survey Vendor	SPH Analytics	SPH Analytics
CAHPS Sample Frame Validation	✓	✓
Primary Source Verification	✓	✓
Medical Record Review Validation	✓	✓
IDSS Review	✓	✓

Table 3 indicates that the audit conducted for the MCOs included all of the listed validation activities. As required, the MCOs used an NCQA LO to perform the annual HEDIS audits. In addition, the MCOs 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). HSAG also determined that the data collected and reported for the Department-selected measures followed NCQA HEDIS methodology. Therefore, rates and audit results are 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 information system (IS) capabilities for accurate HEDIS reporting. HSAG reviewed the IS capabilities assessments of the MCOs, which were conducted by LOs and included in the FARs. The reviews 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" and "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 LOs determined if the MCOs 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 *HEDIS MY 2022 Compliance Audit: Standards, Policies, and Procedures, Volume 5*, the LOs evaluated IS compliance with NCQA's IS standards. These standards detail the minimum requirements that the MCOs' 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 LOs rated the impact on HEDIS reporting capabilities and, particularly, any measure that could be impacted. The MCOs 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, both MCOs' information systems and processes were compliant with all IS standards and the HEDIS determination reporting requirements.

The section that follows provides a summary of the MCOs' key findings for each IS standard as noted in its FAR. 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 MY 2022 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.	Both MCOs were compliant with IS Standard 1.0 for medical services data capture and processing. Both MCOs only accepted industry standard codes on industry standard forms. All data elements required for HEDIS reporting were adequately captured.
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 MCOs continually assess data completeness and take steps to improve performance. • The MCOs effectively monitor the quality and accuracy of electronic submissions. • The MCOs have effective control processes for the transmission of enrollment data.	Both MCOs were compliant with IS Standard 2.0 for enrollment data capture and processing. The MCOs had policies and procedures in place for submitting electronic data. Data elements required for reporting were captured. Adequate validation processes were in place, ensuring data accuracy.
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.	Both MCOs were compliant with IS Standard 3.0 for practitioner data capture and processing. The MCOs appropriately captured and documented practitioner data. Data validation processes were in place to verify practitioner data. In addition, for accuracy and completeness, the MCOs reviewed all provider data received from delegated entities.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
• Data completeness is assessed and steps are taken to improve performance. • 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 MRR 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.	Both MCOs were compliant with IS Standard 4.0 for MRR processes. Data collection tools used by the MCOs were able to capture all data fields necessary for HEDIS reporting. Sufficient validation processes were in place to ensure data accuracy. However, HSAG did not review this step since the State requires administrative rates only.
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. • Data approved for electronic clinical data system (ECDS) reporting met reporting requirements. • NCQA-validated data resulting from the Data Aggregator Validation (DAV) program met reporting requirements.	Both MCOs were compliant with IS Standard 5.0 for supplemental data capture and processing. The HEDIS repository contained all data fields required for HEDIS reporting. In addition, staff members were interviewed to confirm the appropriate quality processes for the data source and to determine if primary source verification was needed on all supplemental data that were in nonstandard form.

NCQA's IS Standards	IS Standards Compliance Findings Based on HEDIS MY 2022 FAR Review
IS 6.0 Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity • Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented. • Data transfers to HEDIS repository from transaction files are accurate and file consolidations, extracts, and derivations are accurate. • Repository structure and formatting are suitable for measures and enable required programming efforts. • Report production is managed effectively and operators perform appropriately. • Vendor performance is monitored against expected performance standards.	Both MCOs were compliant with IS Standard 6.0 for data preproduction processing. File consolidation and data extractions were performed by the MCOs' staff members. Data were verified for accuracy at each data merge point.
IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support HEDIS Reporting Integrity • Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate. • Report production is managed effectively and operators perform appropriately. • HEDIS reporting software is managed properly. • The organization regularly monitors vendor performance against expected performance standards.	Both MCOs were compliant with IS Standard 7.0 for data integration. The MCOs used an NCQA-certified measure vendor for data production and rate calculation.

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 *HEDIS MY 2022 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 LOs produced an initial written report identifying any perceived issues of noncompliance, problematic measures, and recommended opportunities for improvement. The LOs 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; MRRV 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 *HEDIS MY 2022 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., International Classification of Diseases, Tenth Revision, Clinical Modification [ICD-10-CM]; International Classification of Diseases, Tenth Revision, Procedure Coding System [ICD-10-PCS]; CPT[A-1]; Healthcare Common Procedure Coding System [HCPCS]) are used and all characters are captured.

[A-1] Current Procedural Terminology (CPT) codes copyright 2018 American Medical Association (AMA). All rights reserved. CPT is a trademark of the AMA.

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 and file processing procedures are timely and accurate and include sufficient edit checks to ensure accurate entry and processing of submitted data in transaction files for 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, Diagnosis Related Group (DRG), and Diagnostic and Statistical Manual of Mental Disorders (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 organization's 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

MRRV 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 MRR 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.

IS 5.6 Data approved for ECDS reporting met reporting requirements.

IS 5.7 NCQA-validated data resulting from the Data Aggregator Validation (DAV) program met reporting requirements.

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 and file layouts may be reviewed as well, to determine compliance with this standard. Beginning with HEDIS 2014, NCQA provided new validation requirements for auditing supplemental data to ensure that all data included for reporting are complete and have required supporting documentation.

IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

IS 6.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented.

IS 6.2 Data transfers to HEDIS repository from transaction files are accurate.

IS 6.3 File consolidations, extracts, and derivations are accurate.

IS 6.4 Repository structure and formatting are suitable for measures and enable required programming efforts.

IS 6.5 Report production is managed effectively and operators perform appropriately.

IS 6.6 The organization regularly monitors vendor performance against expected performance standards.

Rationale

Prior to data integration and reporting, it is essential that data transfer, consolidation, and control procedures support the integrity of the measure reporting. 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.

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

IS 7.1 Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate.

IS 7.2 Report production is managed effectively and operators perform appropriately.

IS 7.3 Measure reporting software is managed properly with regard to development, methodology, documentation, version control, and testing.

IS 7.4 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. 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.