



Common Health Information Reporting Partnership (CHIRP) Policies and Procedures

**Approved by MNCM Board of Directors
on February 15, 2023
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TABLE OF CONTENTS

<u>Policy</u>	<u>Page</u>
I. CHIRP Governance Committee Policy	1
II. CHIRP TAG Charter	5
III. CHIRP Provider-to-Payer Use Cases Policy	8
IV. CHIRP Provider to Payer Data Standard & Flat File Format for CHIRP Data	9
V. CHIRP Provider to Payer Data Standard & Flat File Format for DAV Certified Standard Supplemental Data	22
VI. CHIRP Patient Matching Algorithm Policy	34
VII. CHIRP Data Integrity Policy	36



Common Health Information Reporting Partnership (CHIRP) Governance Committee Policy

Policy Name: Common Health Information Reporting Partnership (CHIRP) Membership	Effective Date: Approved by MNCM Board, February 15, 2023
Policy Owner: MNCM CHIRP Governance Committee	Review/Revision Date: January 30, 2024
Category of Policy (select one of the following): MN Community Measurement – CHIRP Policy	

1.1 Program Definition and Scope

The Common Health Information Reporting Partnership (CHIRP) is a program established to empower stakeholders with meaningful data to drive improvement in health care quality, equity, and affordability by facilitating data sharing among health care payers and health care providers for specified use cases.

2.1 Governance Committee Established

The Common Health Information Reporting Partnership (CHIRP) Governance Committee is established to provide ongoing guidance on data sharing programs offered by MNCM through the CHIRP program. The scope of work for the committee includes:

- 2.1 Providing advice to the MNCM Board of Directors on the strategic direction for the program to ensure ongoing alignment with stakeholder needs; specifically, this includes providing recommendations on:
 - 2.1.1 Supported use cases for provider-to-payer data sharing and payer-to-provider data sharing.
 - 2.1.2 Action necessary to ensure ongoing alignment with stakeholder needs. This includes but is not limited to: enhancements to current programs and services, expansions in the scope of programs and services, enhancements/investments needed in technical infrastructure/technologies.
- 2.2 Advising staff on ongoing program operations across five critical domains: governance, legal/policy, finance, technical infrastructure, and business operations.
- 2.3 Engaging Technical Advisory Groups as needed to inform the development of committee recommendations to the Board of Directors.

3.1 CHIRP Governance Committee Leadership

The CHIRP Governance Committee will be led by two co-chairs, appointed by the MNCM Board

Chair and must include one health care payer representative and one health care provider representative.

3.1 Terms: Co-chair terms are two years in length, staggered to ensure continuity. After the initial term, co-chairs have the option to renew for two additional terms. At the end of the third term, co-chairs may reapply for appointment.

3.2 Board Liaison: If neither of the co-chairs is a member of the Board of Directors, the MNCM Board Chair will appoint a committee member who also serves on the Board to act as the committee liaison to the Board of Directors.

4.1 CHIRP Governance Committee Members

CHIRP Governance Committee members are recommended by the co-chairs and approved by the MNCM Board Chair, following an application process. Following the second-year start-up period for the CHIRP Governance Committee, all committee members must be from health care payer organizations and health care provider organizations that are active participants in CHIRP.

4.1 Size: The Governance Committee shall include a minimum of 12 members, including the co-chairs. Additional members may be added at the discretion of the Board Chair up to a maximum of 16 members.

4.2 Terms: When the committee is formed, terms will be established for each position on the committee with all terms ending during month of December. Initial appointments will be staggered, with half of the representatives for each category with terms ending in the odd year, and half of the representatives for each category with terms ending in the even year. Following the initial appointments, committee member terms will be two years in length.

After an appointee has completed one term, the committee member will have the option to renew for two additional terms. At the end of the third term, committee members may reapply for appointment. If a position is vacated, and a new appointment is made outside of the normal cycle, the new appointee will complete the established term, and will have the option to renew for three additional terms.

4.3 Balance: The committee shall include an equal balance of health care payer and health care provider representatives.

Representation Type	Minimum Number of Members
Payer Organizations	6
Provider Organizations (e.g., health systems, hospitals, clinics)	6

4.4 Diversity: In the appointment of members, the committee co-chairs and MNCM Board Chair shall strive to ensure the committee includes diverse representation. Considerations within the overarching representation types include:

- 4.4.1 Health care providers including but not limited to: medical directors, physicians, physician assistants, nurses, and pharmacists
- 4.4.2 Professionals working in finance, data analysis, quality improvement and clinic administration
- 4.4.3 Experience in measurement/quality improvement
- 4.4.4 Race/ethnicity diversity
- 4.4.5 Size of medical group/clinic or payer
- 4.4.6 Geographic diversity - metro vs. non-metro medical group or payer location/populations served
- 4.4.7 Safety net medical groups and payers that serve disadvantaged populations

4.5 Members of the Board of Directors will be directly appointed to the CHIRP Governance Committee by the MNCM Board Chair as appropriate. These members will not be subject to the term limits and application processes of committee members. However, if the committee member has completed their service on the Board of Directors, they must reapply for their position on the CHIRP Governance Committee if they wish to continue serving on the committee.

5.1 Committee Operations

- 5.1 Quorum: 51% of membership present.
- 5.2 Frequency: Meetings will be held semi-annually at minimum, with the frequency adjusted by the co-chairs as needed depending on program needs.
- 5.3 Attendance: Committee members must attend/participate in 50% of the meetings each year. The co-chairs can recommend removal of a CHIRP Governance Committee member if attendance requirements are not met.
- 5.4 Application Process for New Members: Information on openings on the committee will be sent via email to the primary contacts for all CHIRP participating organizations as identified in their annual participant update. The communication will include a link to the online application.
- 5.5 End of Term Process: For community committee members approaching the end of a term, MNCM staff will send an email reminder to confirm continuation of position on the committee. Committee members wishing to resign at the end of their term should submit a written notice of their intent to resign to MNCM staff. MNCM staff will provide the notice of resignation to CHIRP Governance Committee co-chairs. No further action is needed for committee members choosing to continue with their position.
- 5.6 End of Third Term Process: For committee members approaching the end of three terms, MNCM will send an email reminder with the option to reapply for their position.

Committee members wishing to resign at the end of their three terms should submit a written notice of their intent to resign to MNCM staff. MNCM staff will provide the notice of resignation to CHIRP co-chairs. Committee members interested in continuing as a committee member on the CHIRP Governance Committee should reapply for the position. However, the position is not guaranteed to these committee members.

- 5.7 Committee Member Replacement: If a committee member decides to resign from the committee before the end of a term, the committee member cannot transfer their position to another employee within their organization. To fill the vacancy, the process is treated the same as if the committee member resigned at the end of their term – the suggested replacement will need to apply for the position.
- 5.8 Conflict of Interest (COI): At the beginning of each year, committee members will be asked to complete MNCM’s COI form. CHIRP co-chairs will review these forms annually along with any applications for new committee members.



COMMON HEALTH INFORMATION REPORTING PARTNERSHIP (CHIRP) TECHNICAL ADVISORY GROUP

CHARTER

APPROVED BY MNCM BOARD FEBRUARY 15, 2023

Purpose: The Common Health Information Reporting Partnership (CHIRP) Technical Advisory Group (TAG) is established to provide technical guidance and input into the development of CHIRP programs focused on common standards and facilitated data transfers among payers and providers. The scope of its work includes addressing issues pertaining to uniform content, processes, and flow of person-level claims and clinical data shared between payers and providers.

Background and Value Proposition:

As payment systems are changing from traditional fee-for-service to value-based payment models, providers, health systems and payers are becoming more reliant on data than ever before to inform their strategies, achieve goals for value-based care, and earn financial incentives tied to performance. Existing mechanisms for sharing of health care data needed to improve cost and quality performance are fragmented and lack alignment. Variation exists related to timeliness, scope and content of data as well as frequency of and mechanisms for sharing data. This results in duplication of effort and inefficiencies for both payers and providers and poses a significant challenge for efficient care delivery, population health management, and quality measurement – all factors that are key to success in this new environment.

MNCM convened the Common Health Information Reporting Partnership (CHIRP) Workgroup to develop recommendations on how MNCM could assist the community in addressing these challenges. After substantial discussion, this multi-stakeholder group moved forward with development and voluntary adoption of standards to promote alignment on content, processes and flow of person-level claims and clinical data between payers and providers, and subsequently defined a role for MNCM in facilitating data transfers among payers and providers. This TAG is established to do the detailed work to ensure the CHIRP standards remain aligned with evolving stakeholder needs and implementing the facilitated data sharing services according to the common standards adopted by the CHIRP Governance Committee. MNCM will provide substantial staff support for the TAG's work.

Scope: The scope of the TAG's work includes providing technical guidance to advance consistency of content, process, and flow of data for facilitated data transfers among payers and providers. Potential work products may include one or more of the following:

- List of data elements and definitions to be included
- Agreement on uniform timing, frequency, and format for data delivery
- Agreement on uniform mechanisms for sending and receiving data and reports
- Other ideas brought forward by TAG members

Time Commitment and Meeting Schedule

The group is set to meet a minimum of two times a year annually to meet responsibility requirements for the CHIRP Governance Committee. Meetings will be scheduled as followed:

- Spring (after the Spring CHIRP Governance Committee meeting)
- Fall (after the Fall CHIRP Governance meeting)

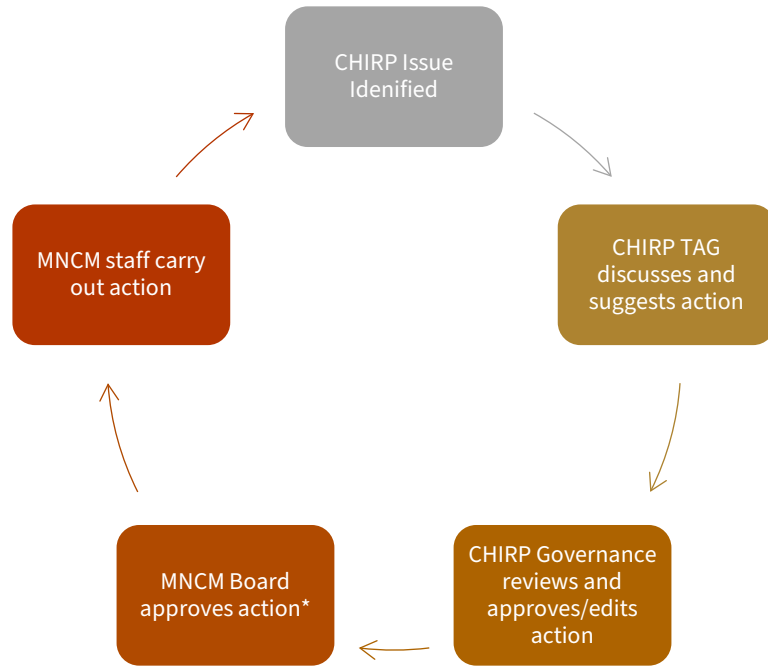
Additional meetings may be held based on the discretion of the CHIRP Governance Committee needs. Each meeting will be a duration of 90-minutes, held virtually. Participants will also need some time for meeting preparation, information gathering between meetings, and internal vetting of proposals.

The following table is provided as a resource to understand the roles and separation of duties between the CHIRP Governance Committee and the CHIRP Technical Advisory Group.

Table 1: Separation of Duties for CHIRP Governance Committee and CHIRP TAG

	CHIRP Governance Committee	CHIRP TAG
Who directs their work?	<ul style="list-style-type: none"> - MNCM Board Adopts Governance Policy, considers recommendations from CHIRP Governance Committee, establishes annual budget 	<ul style="list-style-type: none"> - CHIRP Governance Committee Identifies issues requiring deeper technical guidance and delegates to the CHIRP TAG as appropriate. Considers input from the TAG in formulating recommendations to MNCM Board.
Scope	<ul style="list-style-type: none"> - Annual review of CHIRP Data Standard - Provide ongoing guidance on data sharing programs offered by MNCM through the CHIRP program 	<ul style="list-style-type: none"> - Data enhancements - List of data elements and definitions to be included - Agreement on uniform timing, frequency, and format for data delivery - Agreement on uniform mechanisms for sending and receiving data and reports
Responsibilities	<ul style="list-style-type: none"> - Providing advice to the MNCM Board of Directors on the strategic direction (Use Cases & necessary action related to CHIRP) - Advise MNCM staff on ongoing program operations - Engage CHIRP TAG to investigate recommendations 	<ul style="list-style-type: none"> - Investigate CHIRP technical considerations, needs and best practices for CHIRP governance
Schedule	<p>Meets minimum two times a year</p> <ul style="list-style-type: none"> - Spring <ul style="list-style-type: none"> o Review CHIRP Data Standards o Recommend any enhancements to be made following year Q1 - Fall <ul style="list-style-type: none"> o Strategic Direction for CHIRP o Program Operations 	<p>Meets minimum two times a year</p> <ul style="list-style-type: none"> - Spring <ul style="list-style-type: none"> o Data Enhancement Development - Fall <ul style="list-style-type: none"> o Investigates needs based on Governance Meeting - Ad Hoc meetings as necessary

The following diagram illustrates an example flow of work for the CHIRP TAG, CHIRP Governance Committee, MNCM Board, and MNCM Staff.



*Note: Not all actions will need to obtain MNCM Board approval



Common Health Information Reporting Partnership (CHIRP) Provider-to-Payer Use Cases Policy

Policy Name: Common Health Information Reporting Partnership (CHIRP) Use Cases	Effective Date: Approved by MNCM Board, February 15, 2023
Policy Owner: MNCM CHIRP Governance Committee	Review/Revision Date: February 15, 2023
Category of Policy (select one of the following): MN Community Measurement – CHIRP Policy	

#	Use Case Name	Description	Date Approved/Updated
1	Health Care Provider Authorization to Send CHIRP Provider-to-Payer Clinical Data to Payers	<p>Allow MNCM PIPE participants the option of having their clinical data shared via the MNCM CHIRP program to payer organizations.</p> <ol style="list-style-type: none"> 1. Data would be shared with a payer or payers only if the participant agrees to permit such sharing, and only for uses mutually agreed-upon by the payer and participant as specified in the CHIRP Provider-to-Payer policies and procedures. 2. Patient data would be sent to the payer only if both the following criteria are met: (a) the patient appears on the current Member Enrollment file supplied to MNCM by the payer; and (b) the patient is identified in the PIPE medical group participant’s Demographic File as being covered by the payer on the date of the submission. 	February 15, 2023
2	Health Care Payer Use of CHIRP Provider-to-Payer Clinical Data	The Use Case allows Participants, which are health care payers, to access and use Health Data of individuals insured or covered by a health benefit plan administered by the Health Care Payer, for care management, collection of quality data and risk adjustment. No other access to, and use of, Health Data is permitted under this Use Case.	February 15, 2023



DATA SPECIFICATIONS

Common Health Information Reporting Partnership (CHIRP):

Provider to Payer Data Standard & Flat File Format for CHIRP Data

Version 1

CONTENTS

SUMMARY OF CHANGES	1
CHIRP PROVIDER-TO-PAYER DATA STANDARD	2
Included Data Fields.....	2
Included Clinical Data Types	3
Historical Look Back Periods.....	3
CHIRP DATA FLAT FILE FORMATS	4
CHIRP_Demographic File	4
CHIRP_Encounter/CPT File.....	6
CHIRP_Blood Pressure File	8
CHIRP_Lab/Procedure File	8
DATA MAPPING TABLES	10
Table A: Race Code Mapping	10
Table B: Ethnicity Code Mapping.....	10
Table C: Preferred Language Code Mapping	10
Table D: Provider Specialty Code Mapping	11
Table E: Diagnosis Coding System Code Mapping.....	11

SUMMARY OF CHANGES

Changes as compared to the *CHIRP Provider to Payer Data Standard and Flat File Format v1.3 FINAL 7-11-2023* document:

- To conform to the HL7 C-CDA R2.1 Continuity of Care Document (CCD) format specified by NCQA's Data Aggregator Validation (DAV) program, the following data elements approved for the CHIRP Data Standard by the CHIRP Governance Committee will **not be included in any CCDs**. These data elements **are included** in the CHIRP Data file formats specified in this document. The description and *Included Data Fields* list in the CHIRP Provider-to-Payer Data Standard section has been updated to reflect this change.
 - Patient Status (Demographic File)
 - Preferred Language Other (Demographic File)
 - Provider Specialty – Other (Encounter File)
 - Lab Type (Lab/Procedure File)
 - Procedure Type (Lab/Procedure File)
- The CHIRP Data files will only contain data that has **not** been certified by the DAV program; therefore, the DAV Status fields have been removed from all files. **No data** in these files have been certified as Standard Supplemental data by NCQA's DAV Program.
- Individual file descriptions and file names have been updated for consistency and clarity.

CHIRP PROVIDER-TO-PAYER DATA STANDARD

The CHIRP Provider-to-Payer Data Standard encompasses the data elements currently approved by the CHIRP Governance Committee. The historical look back periods were defined as an accepted use case by the committee.

The HL7 C-CDA R2.1 Continuity of Care Document (CCD) format specified by NCQA’s Data Aggregator Validation (DAV) program does not allow for inclusion of all committee approved data elements. The fields marked with an asterisk in the table below, including Patient Status, Preferred Language Other, Lab Type, Procedure Type, and Provider Specialty – Other, **are not included** in the DAV Certified Standard Supplemental Data file formats or any outbound CCDs. They **are included** in the CHIRP Data file formats.

Matched patients/members from DAV Certified medical groups are included in the CHIRP Data files for the express purpose of sharing these five data elements. All other CHIRP specified data elements for these patients/members are present in the DAV Certified Standard Supplemental Data files and CCDs.

Included Data Fields	
Patient ID	Lab Service Date
Patient Full First Name	Lab Code
Patient Last Name	Lab Type*
Patient Date of Birth (DOB)	Lab Result
Patient Sex at Birth	Procedure Date
Patient Date of Death (DOD)	Procedure Code
Patient Status*	Procedure Type*
Race1	Date of Encounter
Race2	Encounter / CPT Service Code
Race3	Encounter Clinic Name
Race4	Provider NPI <i>(associated with encounter)</i>
Race5	Provider Specialty <i>(associated with encounter)</i>
Ethnicity	Provider Specialty – Other <i>(associated with encounter)*</i>
Preferred Language	Height <i>(associated with encounter)</i>
Preferred Language Other*	Weight <i>(associated with encounter)</i>
Street Address	Tobacco Status <i>(associated with encounter)</i>
City	Diagnosis Coding System <i>(associated with encounter)</i>
State	Diagnosis Code(s) <i>(associated with encounter)</i>
ZIP Code	
Insurance	
Insurance Member ID	
Blood Pressure Date	
Blood Pressure Time	
Systolic Reading	
Diastolic Reading	

Included Clinical Data Types	
Mammography HbA1C Value Cervical Cytology HR-HPV Test Chlamydia Test Colonoscopy CT Colonography FIT-DNA Flexible Sigmoidoscopy FOBT uACR Test eGFR Test Tobacco Use	<u>Immunizations</u> <ul style="list-style-type: none"> • DTaP Immunization • Inactivated Polio Immunization • Measles Mumps Rubella Immunization • Measles Rubella Immunization • Measles Immunization • Mumps Immunization • Rubella Immunization • Haemophilus Influenzae Immunization • Hepatitis B Immunization • Varicella Zoster Immunization • Pneumococcal Conjugate Immunization • Hepatitis A Immunization • Rotavirus Immunization • Influenza Immunization • Human Papillomavirus Immunization • Meningococcal Conjugate Immunization • Tdap Immunization

Historical Look Back Periods
<ul style="list-style-type: none"> • Demographic File will contain most current information, no historical data will be provided • Encounter File will include one year of historical data from last date of service in the cycle • Blood Pressure file will be one year of data from last date of service in the cycle • Lab/Procedure File will have measure specific look back periods <ul style="list-style-type: none"> ○ Within 10 years of last date of service in the cycle: Colonoscopy ○ Within five years of last date of service in the cycle: cervical cytology, high risk human papillomavirus (hrHPV), sigmoidoscopies, CT colonography ○ Within four years of last date of service in the cycle: immunizations ○ Within three years of last date of service in the cycle: mammography, and stool DNA (sDNA) with FIT tests ○ Within one year of last date of service in the cycle: FOBT, and lab tests (a1c, uACR, eGFR)

CHIRP DATA FLAT FILE FORMATS

These flat file formats contain all data elements specified in the CHIRP data standard. The flat files are offered as a complement to the corresponding NCQA specified CCD file(s) for use by payers unable to ingest CCDs. **None of the data** in these files have been certified as Standard Supplemental data by NCQA's DAV Program.

CHIRP_Demographic File

Contains one row for each patient contained in any of the other files. Data only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled <i>Insurance Coverage Data Elements, Field Specifications & Codes</i> for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters
5	Patient Full First Name	Full first name of the patient.	String
6	Patient Last Name	Last name of the patient.	String
7	Patient Date of Birth (DOB)		yyyy-mm-dd
8	Patient Sex at Birth	F = Female M = Male U = Unknown/Undefined	Text; 1 character
9	Patient Date of Death (DOD)		yyyy-mm-dd
10	Patient Status	0 = Deceased 1 = Alive	Number, 1 digit
11	Race1	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
12	Race2	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String

CHIRP_Demographic File

Contains one row for each patient contained in any of the other files. Data only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
13	Race3	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
14	Race4	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
15	Race5	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
16	Ethnicity	Patient reported Ethnicity. If the patient was not asked for their ethnicity or if ethnicity was left blank by patient, the field is blank. See Table B for code map.	String
17	Preferred Language	Patient reported preferred language. If the patient was not asked for their preferred language or if preferred language was left blank by patient, the field is blank. See Table C for code map.	Text
18	Preferred Language Other	May contain text description of preferred language.	String; up to 50 characters
19	Street Address	Patient primary residence	String; up to 50 characters
20	City	Patient primary residence	String; up to 50 characters
21	State	Patient primary residence, Standard two-character state abbreviation .	Text; 2 characters
22	ZIP Code	Patient primary residence, Minimum of five digits	Number

CHIRP_Encounter/CPT File

This encounter level information includes 1) value set defined services including those from the *Included Clinical Data Types* list and 2) clinical data that typically occurs once per encounter (e.g., weight, tobacco status, diagnoses). The file contains one row per service code related to an encounter. Data elements only present if available and included in the CHIRP provider-to-payer data standard. If the Encounter Service Code is a lab or procedure, the data may also be present in the Lab/Procedure File.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled <i>Insurance Coverage Data Elements, Field Specifications & Codes</i> for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters
5	Date of Encounter		yyyy-mm-dd
6	Encounter / CPT Service Code		String; up to 50 characters
7	Encounter Clinic Name	Clinic where encounter occurred	Text
8	Provider NPI	<ul style="list-style-type: none"> ▪ National Provider Identifier for provider associated with the encounter. ▪ 10 digits 	Number; 10 digits
9	Provider Specialty	Provider's board-certified specialty. If the provider is not a physician, this is the board-certified specialty of the supervising physician. See Table D for code map.	Text
10	Provider Specialty - Other	May be populated with text description of provider's specialty	String; up to 50 characters
11	Height	<ul style="list-style-type: none"> ▪ Height collected by clinical staff during encounter ▪ Value in inches, including decimals if applicable 	Number
12	Weight	<ul style="list-style-type: none"> ▪ Weight collected by clinical staff during encounter ▪ Value in pounds, including decimals if applicable 	Number
13	Tobacco Status	Tobacco status within two years of the encounter 0 = Tobacco Free; patient does not currently use tobacco 1 = Current tobacco user	Number; 1 digit
14	Diagnosis Coding System	HL7 Object Identifier; made up of a series of numbers and dots, specifying type of code: ICD-10, ICD-9, SNOMED; See Table E for code map.	Text

CHIRP_Encounter/CPT File

This encounter level information includes 1) value set defined services including those from the *Included Clinical Data Types* list and 2) clinical data that typically occurs once per encounter (e.g., weight, tobacco status, diagnoses). The file contains one row per service code related to an encounter. Data elements only present if available and included in the CHIRP provider-to-payer data standard. If the Encounter Service Code is a lab or procedure, the data may also be present in the Lab/Procedure File.

Element Order	Field Name	Details	Format/Field Length
15 to 64	Diagnosis Code(s)	<ul style="list-style-type: none"> ▪ Diagnosis associated with the encounter ▪ Up to 50 diagnoses per encounter may be present 	String; up to 50 characters

CHIRP_Blood Pressure File

The file contains one row per ambulatory blood pressure that was not associated with a diagnostic test or surgical procedure. Data elements only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled <i>Insurance Coverage Data Elements, Field Specifications & Codes</i> for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters
5	Blood Pressure Date		yyyy-mm-dd
6	Blood Pressure Time		Military time: hh:mm:ss
7	Systolic Reading		Number
8	Diastolic Reading		Number

CHIRP_Lab/Procedure File

Contains value set defined labs and procedures from the *Included Clinical Data Types* list. The file contains one row per lab or procedure. Data elements only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled <i>Insurance Coverage Data Elements, Field Specifications & Codes</i> for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters

CHIRP_Lab/Procedure File

Contains value set defined labs and procedures from the *Included Clinical Data Types* list. The file contains one row per lab or procedure. Data elements only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
5	Lab Service Date		yyyy-mm-dd
6	Lab Code	Value set specified code for lab performed by submitting medical group.	String; up to 50 characters
7	Lab Type	Value set specified labs contained in patient record performed outside submitting medical group, text description of lab type	String; up to 50 characters
8	Lab Result	Result for value set specified labs	String; up to 50 characters
9	Procedure Date	Date that the procedure was performed.	yyyy-mm-dd
10	Procedure Code	Value set specified procedure code performed by submitting medical group. Codes may include CPT, CVX, SNOMED, HCPCS, ICD10-PCS, etc.	String; up to 50 characters
11	Procedure Type	Value set specified procedures contained in patient record performed outside submitting medical group, text description of procedure type	String; up to 50 characters

DATA MAPPING TABLES

Table A: Race Code Mapping

<u>Race</u>	<u>HL7 Compliant Code</u>
Asian	2028-9
Black	2054-5
Indigenous	1002-5
Native Hawaiian/Other Pacific Islander	2076-8
Other	Unknown
White	2106-3
Chose not to disclose or patient-reported as Unknown	Unknown

Table B: Ethnicity Code Mapping

<u>Ethnicity</u>	<u>HL7 Compliant Code</u>
Hispanic/Latinx	2135-2
Not Hispanic/Latinx	2186-5
Chose not to disclose or patient-reported as Unknown	UNK

Table C: Preferred Language Code Mapping

<u>Language</u>	<u>HL7 Compliant Code</u>
Amharic	am
Arabic	ar
Bosnian	bs
Burmese	my
Cambodian	Cambodian
Cantonese	Cantonese
Chinese	zh
English	en
French	fr
German	de
Hearing Impaired	Hearing Impaired
Hindi	hi
Hmong	hmn
Japanese	ja
Karen	kar
Korean	ko
Laotian	Laotian
Mandarin	Mandarin
Oromo	om
Polish	pl
Romanian	ro
Russian	ru
Sign Language	sgn
Somali	so
Spanish	es
Swahili	sw
Tagalog	tl
Thai	th
Tibetan	bo

<u>Language</u>	<u>HL7 Compliant Code</u>
Tigrinya	ti
Urdu	ur
Vietnamese	vi
Yoruba	yo

Table D: Provider Specialty Code Mapping

<u>Provider Specialty</u>	<u>HL7 Compliant Code</u>
Family Medicine Physician	207Q00000X
Internal Medicine Physician	207R00000X
Geriatric Medicine (Internal Medicine) Physician	207RG0300X
Cardiovascular Disease Physician	207RC0000X
Endocrinology	207RE0101X
Psychiatry Physician	2084P0800X
Obstetrics & Gynecology Physician	207V00000X
Allergy & Immunology Physician	207K00000X
Thoracic Surgery (Cardiothoracic Vascular Surgery) Physician	208G00000X
Colon & Rectal Surgery Physician	208C00000X
Dermatology Physician	207N00000X
Emergency Medicine Physician	207P00000X
Gastroenterology Physician	207RG0100X
Nephrology Physician	207RN0300X
Neurology Physician	2084N0400X
Neurological Surgery Physician	207T00000X
Occupational Medicine Physician	2083X0100X
Hematology & Oncology Physician	207RH0003X
Ophthalmology Physician	207W00000X
Orthopaedic Surgery Physician	207X00000X
Otolaryngology Physician	207Y00000X
Pediatrics Physician	208000000X
Physical Therapist	208100000X
Pulmonary Disease Physician	207RP1001X
Diagnostic Radiology Physician	2085R0202X
Rheumatology Physician	207RR0500X
Surgery Physician	208600000X
Urology Physician	208800000X
Neonatal-Perinatal Medicine Physician	2080N0001X
Radiation Oncology Physician	2085R0001X
Anesthesiology Physician	207L00000X
Chiropractor	111N00000X

Table E: Diagnosis Coding System Code Mapping

<u>Diagnosis Coding System</u>	<u>HL7 Compliant Code</u>
ICD-10	2.16.840.1.113883.6.90
ICD-9	2.16.840.1.113883.6.103
SNOMED	2.16.840.1.113883.6.96



DATA SPECIFICATIONS

Common Health Information Reporting Partnership (CHIRP):

Provider to Payer Data Standard & Flat File Format for DAV Certified Standard Supplemental Data

Version 1

CONTENTS

SUMMARY OF CHANGES	1
CHIRP PROVIDER-TO-PAYER DATA STANDARD	2
Included Data Fields.....	2
Included Clinical Data Types	3
Historical Look Back Periods.....	3
DAV CERTIFIED STANDARD SUPPLEMENTAL DATA FLAT FILE FORMATS	4
DAV_Demographic File.....	4
DAV_Encounter/CPT File.....	6
DAV_Blood Pressure File	7
DAV_Lab/Procedure File.....	8
DATA MAPPING TABLES	9
Table A: Race Code Mapping	9
Table B: Ethnicity Code Mapping.....	9
Table C: Preferred Language Code Mapping	9
Table D: Provider Specialty Code Mapping.....	10
Table E: Diagnosis Coding System Code Mapping.....	10

SUMMARY OF CHANGES

Changes as compared to the *CHIRP Provider to Payer Data Standard and Flat File Format v1.3 FINAL 7-11-2023* document:

- To conform to the HL7 C-CDA R2.1 Continuity of Care Document (CCD) format specified by NCQA's Data Aggregator Validation (DAV) program, the following data elements approved for the CHIRP Data Standard by the CHIRP Governance Committee have been removed from the flat file formats for DAV Certified Standard Supplemental Data. The description and *Included Data Fields* list in the CHIRP Provider-to-Payer Data Standard section has been updated to reflect this change.
 - Patient Status (Demographic File)
 - Preferred Language Other (Demographic File)
 - Provider Specialty – Other (Encounter File)
 - Lab Type (Lab/Procedure File)
 - Procedure Type (Lab/Procedure File)
- To align with the requirements of the DAV program, this flat file set will only contain those medical groups that have successfully completed DAV certification. Therefore, the DAV Status fields have been removed from all files.
- Individual file descriptions and file names have been updated for consistency and clarity.

CHIRP PROVIDER-TO-PAYER DATA STANDARD

The CHIRP Provider-to-Payer Data Standard encompasses the data elements currently approved by the CHIRP Governance Committee. The historical look back periods were defined as an accepted use case by the committee.

Included Data Fields	
Patient ID	Lab Service Date
Patient Full First Name	Lab Code
Patient Last Name	Lab Result
Patient Date of Birth (DOB)	Procedure Date
Patient Sex at Birth	Procedure Code
Patient Date of Death (DOD)	Date of Encounter
Race1	Encounter / CPT Service Code
Race2	Encounter Clinic Name
Race3	Provider NPI <i>(associated with encounter)</i>
Race4	Provider Specialty <i>(associated with encounter)</i>
Race5	Height <i>(associated with encounter)</i>
Ethnicity	Weight <i>(associated with encounter)</i>
Preferred Language	Tobacco Status <i>(associated with encounter)</i>
Street Address	Diagnosis Coding System <i>(associated with encounter)</i>
City	Diagnosis Code(s) <i>(associated with encounter)</i>
State	
ZIP Code	
Insurance	
Insurance Member ID	
Blood Pressure Date	
Blood Pressure Time	
Systolic Reading	
Diastolic Reading	

The HL7 C-CDA R2.1 Continuity of Care Document (CCD) format specified by NCQA’s Data Aggregator Validation (DAV) program does not allow for inclusion of all committee approved data elements. The fields approved by the Committee but **not included** in the DAV-certified standard supplemental data file include Patient Status, Preferred Language Other, Lab Type, Procedure Type, and Provider Specialty – Other.

Included Clinical Data Types	
Mammography HbA1C Value Cervical Cytology HR-HPV Test Chlamydia Test Colonoscopy CT Colonography FIT-DNA Flexible Sigmoidoscopy FOBT uACR Test eGFR Test Tobacco Use	<u>Immunizations</u> <ul style="list-style-type: none"> • DTaP Immunization • Inactivated Polio Immunization • Measles Mumps Rubella Immunization • Measles Rubella Immunization • Measles Immunization • Mumps Immunization • Rubella Immunization • Haemophilus Influenzae Immunization • Hepatitis B Immunization • Varicella Zoster Immunization • Pneumococcal Conjugate Immunization • Hepatitis A Immunization • Rotavirus Immunization • Influenza Immunization • Human Papillomavirus Immunization • Meningococcal Conjugate Immunization • Tdap Immunization

Historical Look Back Periods
<ul style="list-style-type: none"> • Demographic File will contain most current information, no historical data will be provided • Encounter File will include one year of historical data from last date of service in the cycle • Blood Pressure file will be one year of data from last date of service in the cycle • Lab/Procedure File will have measure specific look back periods <ul style="list-style-type: none"> ○ Within 10 years of last date of service in the cycle: Colonoscopy ○ Within five years of last date of service in the cycle: cervical cytology, high risk human papillomavirus (hrHPV), sigmoidoscopies, CT colonography ○ Within four years of last date of service in the cycle: immunizations ○ Within three years of last date of service in the cycle: mammography, and stool DNA (sDNA) with FIT tests ○ Within one year of last date of service in the cycle: FOBT, and lab tests (a1c, uACR, eGFR)

DAV CERTIFIED STANDARD SUPPLEMENTAL DATA FLAT FILE FORMATS

These flat files are offered as a complement to the corresponding NCQA specified CCD file(s) for the DAV program for use by payers unable to ingest CCDs.

DAV_Demographic File

Contains one row for each patient contained in any of the other files. Data only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled <i>Insurance Coverage Data Elements, Field Specifications & Codes</i> for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters
5	Patient Full First Name	Full first name of the patient.	String
6	Patient Last Name	Last name of the patient.	String
7	Patient Date of Birth (DOB)		yyyy-mm-dd
8	Patient Sex at Birth	F = Female M = Male U = Unknown/Undefined	Text; 1 character
9	Patient Date of Death (DOD)		yyyy-mm-dd
10	Race1	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
11	Race2	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
12	Race3	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String

DAV_Demographic File

Contains one row for each patient contained in any of the other files. Data only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
13	Race4	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
14	Race5	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
15	Ethnicity	Patient reported Ethnicity. If the patient was not asked for their ethnicity or if ethnicity was left blank by patient, the field is blank. See Table B for code map.	String
16	Preferred Language	Patient reported preferred language. If the patient was not asked for their preferred language or if preferred language was left blank by patient, the field is blank. See Table C for code map.	Text
17	Street Address	Patient primary residence	String; up to 50 characters
18	City	Patient primary residence	String; up to 50 characters
19	State	Patient primary residence, Standard two-character state abbreviation .	Text; 2 characters
20	ZIP Code	Patient primary residence, Minimum of five digits	Number

DAV_Encounter/CPT File

This encounter level information includes 1) value set defined services including those from the *Included Clinical Data Types* list and 2) clinical data that typically occurs once per encounter (e.g., weight, tobacco status, diagnoses). The file contains one row per service code related to an encounter. Data elements only present if available and included in the CHIRP provider-to-payer data standard. If the Encounter Service Code is a lab or procedure, the data may also be present in the Lab/Procedure File.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled <i>Insurance Coverage Data Elements, Field Specifications & Codes</i> for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters
5	Date of Encounter		yyyy-mm-dd
6	Encounter / CPT Service Code		String; up to 50 characters
7	Encounter Clinic Name	Clinic where encounter occurred	Text
8	Provider NPI	<ul style="list-style-type: none"> ▪ National Provider Identifier for provider associated with the encounter. ▪ 10 digits 	Number; 10 digits
9	Provider Specialty	Provider's board-certified specialty. If the provider is not a physician, this is the board-certified specialty of the supervising physician. See Table D for code map.	Text
10	Height	<ul style="list-style-type: none"> ▪ Height collected by clinical staff during encounter ▪ Value in inches, including decimals if applicable 	Number
11	Weight	<ul style="list-style-type: none"> ▪ Weight collected by clinical staff during encounter ▪ Value in pounds, including decimals if applicable 	Number
12	Tobacco Status	Tobacco status within two years of the encounter 0 = Tobacco Free; patient does not currently use tobacco 1 = Current tobacco user	Number; 1 digit
13	Diagnosis Coding System	HL7 Object Identifier; made up of a series of numbers and dots, specifying type of code: ICD-10, ICD-9, SNOMED; See Table E for code map.	Text
14 to 63	Diagnosis Code(s)	<ul style="list-style-type: none"> ▪ Diagnosis associated with the encounter ▪ Up to 50 diagnoses per encounter may be present 	String; up to 50 characters

DAV_Blood Pressure File

The file contains one row per ambulatory blood pressure that was not associated with a diagnostic test or surgical procedure. Data elements only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled <i>Insurance Coverage Data Elements, Field Specifications & Codes</i> for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters
5	Blood Pressure Date		yyyy-mm-dd
6	Blood Pressure Time		Military time: hh:mm:ss
7	Systolic Reading		Number
8	Diastolic Reading		Number

DAV_Lab/Procedure File

Contains value set defined labs and procedures from the *Included Clinical Data Types* list. The file contains one row per lab or procedure. Data elements only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled Insurance Coverage Data Elements, Field Specifications & Codes for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters
5	Lab Service Date		yyyy-mm-dd
6	Lab Code	Value set specified code for lab performed by submitting medical group.	String; up to 50 characters
7	Lab Result	Result for value set specified labs	String; up to 50 characters
8	Procedure Date	Date that the procedure was performed.	yyyy-mm-dd
9	Procedure Code	Value set specified procedure code performed by submitting medical group. Codes may include CPT, CVX, SNOMED, HCPCS, ICD10-PCS, etc.	String; up to 50 characters

DATA MAPPING TABLES

Table A: Race Code Mapping

<u>Race</u>	<u>HL7 Compliant Code</u>
Asian	2028-9
Black	2054-5
Indigenous	1002-5
Native Hawaiian/Other Pacific Islander	2076-8
Other	Unknown
White	2106-3
Chose not to disclose or patient-reported as Unknown	Unknown

Table B: Ethnicity Code Mapping

<u>Ethnicity</u>	<u>HL7 Compliant Code</u>
Hispanic/Latinx	2135-2
Not Hispanic/Latinx	2186-5
Chose not to disclose or patient-reported as Unknown	UNK

Table C: Preferred Language Code Mapping

<u>Language</u>	<u>HL7 Compliant Code</u>
Amharic	am
Arabic	ar
Bosnian	bs
Burmese	my
Cambodian	Cambodian
Cantonese	Cantonese
Chinese	zh
English	en
French	fr
German	de
Hearing Impaired	Hearing Impaired
Hindi	hi
Hmong	hmn
Japanese	ja
Karen	kar
Korean	ko
Laotian	Laotian
Mandarin	Mandarin
Oromo	om
Polish	pl
Romanian	ro
Russian	ru
Sign Language	sgn
Somali	so
Spanish	es
Swahili	sw
Tagalog	tl
Thai	th
Tibetan	bo

<u>Language</u>	<u>HL7 Compliant Code</u>
Tigrinya	ti
Urdu	ur
Vietnamese	vi
Yoruba	yo

Table D: Provider Specialty Code Mapping

<u>Provider Specialty</u>	<u>HL7 Compliant Code</u>
Family Medicine Physician	207Q00000X
Internal Medicine Physician	207R00000X
Geriatric Medicine (Internal Medicine) Physician	207RG0300X
Cardiovascular Disease Physician	207RC0000X
Endocrinology	207RE0101X
Psychiatry Physician	2084P0800X
Obstetrics & Gynecology Physician	207V00000X
Allergy & Immunology Physician	207K00000X
Thoracic Surgery (Cardiothoracic Vascular Surgery) Physician	208G00000X
Colon & Rectal Surgery Physician	208C00000X
Dermatology Physician	207N00000X
Emergency Medicine Physician	207P00000X
Gastroenterology Physician	207RG0100X
Nephrology Physician	207RN0300X
Neurology Physician	2084N0400X
Neurological Surgery Physician	207T00000X
Occupational Medicine Physician	2083X0100X
Hematology & Oncology Physician	207RH0003X
Ophthalmology Physician	207W00000X
Orthopaedic Surgery Physician	207X00000X
Otolaryngology Physician	207Y00000X
Pediatrics Physician	208000000X
Physical Therapist	208100000X
Pulmonary Disease Physician	207RP1001X
Diagnostic Radiology Physician	2085R0202X
Rheumatology Physician	207RR0500X
Surgery Physician	208600000X
Urology Physician	208800000X
Neonatal-Perinatal Medicine Physician	2080N0001X
Radiation Oncology Physician	2085R0001X
Anesthesiology Physician	207L00000X
Chiropractor	111N00000X

Table E: Diagnosis Coding System Code Mapping

<u>Diagnosis Coding System</u>	<u>HL7 Compliant Code</u>
ICD-10	2.16.840.1.113883.6.90
ICD-9	2.16.840.1.113883.6.103
SNOMED	2.16.840.1.113883.6.96



Common Health Information Reporting Partnership (CHIRP) Patient Matching Algorithm Policy

Policy Name: Common Health Information Reporting Partnership (CHIRP) Patient Matching Algorithm	Effective Date: Approved by MNCM Board, February 15, 2023
Policy Owner: MNCM CHIRP Governance Committee	Review/Revision Date: January 30, 2024
Category of Policy: MN Community Measurement – CHIRP Policy	

The following algorithm will be used to confirm matched patients for approved CHIRP use cases:



**Common Health Information
Reporting Partnership (CHIRP)
Data Integrity Policy**

Policy Name: Common Health Information Reporting Partnership (CHIRP) Data Integrity Policy	Effective Date: Approved by MNCM Board, February 15, 2023
Policy Owner: MNCM CHIRP Governance Committee	Review/Revision Date: February 15, 2023
Category of Policy (select one of the following): MN Community Measurement – CHIRP Policy	

Medical Group Participation in the NCQA Data Aggregator Validation (DAV) Program

Medical groups taking part in the Common Health Information Reporting Partnership (CHIRP) must actively participate in the Primary Source Verification (PSV) portions of the DAV certification process. This process will occur at least annually. Active participation includes, but is not limited to:

- Notifying MNCM regarding all EHR and query changes that impact data prepared for submission to the Process Intelligence Performance Engine (PIPE) in a timely manner.
- Taking part in pre-PSV training as determined by MNCM.
 - Training to include expectations for the PSV process and specific timelines.
- Designating a primary contact that will be readily available to manage inquiries and requests from MNCM for the duration of the PSV process.
- Providing MNCM with screen prints or screen shots of patient records from the EHR as requested.
- Adhering to agreed upon turnaround times.

Payer Data Integrity

Payers that submit enrollment data for patient matching with provider submitted insurance data and product attachment will undergo a rigorous validation process to ensure data accuracy and reliability. Validation is conducted as part of onboarding into PIPE and prior to the regular transfer of clinical data to payers and use of insurance product for various analysis purposes. Ongoing validation is conducted as well.

- Prior to data submission, payers will complete training to review the *PIPE Data File Field Specifications for Health Plan Member Verification* and the file import process. MNCM also reviews an overview of the validation process and project plan with the payer data team.
- Upfront validation is conducted before data is imported into the PIPE system.
 - An audit is conducted of the payer’s query/SQL code that will be used to extract enrollment data. MNCM verifies that the query is free from any limitations or parameters that may exclude the necessary data.
 - After the payer extracts the data, an audit of the data file is conducted to ensure that the data file is constructed correctly for ingestion into the PIPE system, data is in the correct format, and the requested data elements are included as expected.
- After the first data file is imported into the PIPE system for testing, import errors produced by the PIPE system are evaluated by the payer and MNCM.

- The number of patients submitted, and the number/percentage of patients matched are evaluated by the payer and MNCM.
- During onboarding, output files for the NCQA specified CCD file and CHIRP specified flat file for delivery to the payer will be produced. The payer and MNCM review the output files, and an audit of a random selection of verified patients is conducted to ensure appropriate matching of provider and payer data elements. Data format integrity is also checked.
- Ongoing validation is conducted to ensure the reliability and integrity of the patient enrollment data. Payers are requested to review this policy on an annual basis and provide any updates to MNCM about changes to their process, system, or expected results.

Any issues or errors identified during the validation process that require corrections are reviewed by and discussed between the payer and MNCM.

Additional details are available in the *PIPE Data Validation* tip sheet for payers.

Information Management Access Plan

MNCM is committed to ensuring the confidentiality, integrity, and availability of all protected health information (PHI/ePHI), confidential and sensitive data (hereafter referred to as covered information) it creates, receives, maintains, and/or transmits. This purpose the Information Management Access Plan defines how MNCM manages access to covered information and supporting information systems for CHIRP and related systems.

Scope & Goals - Information Management Plan

The goals of information access management are to ensure:

- Access to covered information and system resources is granted under the minimum necessary needed to perform assigned job responsibilities.
- Access is promptly granted, adjusted, suspended or terminated by the proper authority (e.g. system owner, supervisor, etc.)
- Users are being positively identified before granting access to covered information and system resources.
- Access is adjusted when appropriate (i.e. promotion/demotion, job change, new clinic etc.)
- Access is promptly removed when an individual's employment is ended.
- System/Application owners perform periodic audits to detect or prevent instances of excessive access.

Responsibilities – Information Management Plan

Information Security Officer

MNCM's Information Security Officer (ISO) in partnership with the organization's Privacy Officer, are responsible for maintenance, interpretation and enforcement of this policy/procedure.

Privacy Officer

MNCM 's Privacy Officer in partnership with the organization's ISO, are responsible for maintenance, interpretation and enforcement of this policy/procedure.

System Administrators

Responsibilities include, but are not limited to the following:

- Add, remove, change or suspend access as defined by this policy.
- Perform account maintenance as defined by this policy.

System/Application Owners

Responsibilities include, but are not limited to the following:

- Approving all requests for access to their respective systems/applications.
- Ensuring access rights to the system/application are based on minimum necessary.
- Maintaining a list of all users (individuals, contractors, and business associates) with access to PHI and other covered information.
- Ensuring access rights to their respective systems/applications are accurate through the practice of periodic revalidation as described by this policy.
- Ensure User IDs that were previously used and removed must not be re-used for a completely different person.

User Registration and Management

Access to MNMCM systems will not be allowed without proper verification of identity. Proper verification of identity is the completion of some of the following:

- PIPE User Request Portal
- PIPE Agreement Completion
- CHIRP Agreement
- Other agreements that are identified

To enforce minimum necessary requirements, MNMCM will implement role-based security in addition to limiting access to application functions through the use of application security that controls access to menus/screens based on the role.

Application access control will be managed individually by the application and not as a group or system. This is especially crucial for applications that communicate with each other. It will not be assumed that if a user has access rights to one application, that they also have rights to the other application.

Account types shall be identified (individual, system, department, etc.). The use of group, shared or generic accounts and passwords is prohibited.

Account Management

Account Maintenance – System Administrators will be responsible for reviewing performing monthly maintenance associated with the clean-up of unnecessary and dormant accounts. System administrators will:

- Disable default and unnecessary system accounts. If accounts must be maintained, the password to the account will be changed and privileges reduced to the lowest level of access.
- Configure automated mechanisms to assist in system account management including provisioning and de-provisioning user accounts, notifying appropriate account managers of changes in access, disabling emergency accounts within 24 hours, and temporary accounts within a fixed duration not to exceed 365 days.