

## P4P Appeals Process - 2011

### Purpose

All involved in producing P4P results strive to achieve 100 percent accuracy of the final results. However, in previous years, there have been a few instances where physician organizations (PO), even after participating in a validation stage, have disagreed with data in their preliminary reports and appealed for changes in their results. The process outlined below is proposed as a formal process to guide the resolution of such appeals.

### Content of Appeals

This process applies to:

- Clinical results
- Patient Experience results
- IT-Enabled Systemness results
- Coordinated Diabetes Care results

It does **not** apply to health plan payment methodology or amount.

### Procedure

1. Notification of appeal rights and instructions on how to submit an appeal distributed to physician organizations and health plans with preliminary performance results (scheduled for June 24, 2011).
2. Physician organization/health plan submits an appeal to IHA any time after the validation process, but no later than five (5) business days after receiving their preliminary results (by June 30, 2011, 5:00 pm PT).
3. IHA sends e-mail of acknowledgement to physician organization/health plan within one (1) business day of receipt and determines whether it requires Appeals Review Panel involvement.
4. Appropriate appeals are forwarded to the Appeals Review Panel for review and final resolution within seven (7) business days. Panel reviews:
  - a. Appeal request form
  - b. Supporting documentation
  - c. Summary from the P4P Data Aggregator describing source and reason for possible error, scope of change requested and recommendation for resolution
5. IHA communicates final findings to the physician organization/health plan within one (1) business day of determination.
6. IHA works with the appropriate entities to appropriately address and resolve outstanding appeals within five (5) business days, including data resubmission as needed.
7. NCQA re-runs results, as needed, and distributes final reports to health plans by July 11, 2011 and to physician organizations by July 20, 2011.

## Handling of Specific Appeal Types

Appeals that P4P staff can reject:

- Missed deadlines by PO or PO's auditor

Appeals that P4P staff can approve and resolve:

- Health Plan calculation/data submission error
- Auditor error
- Data aggregation error

## 2011 Appeals Review Panel

Health plans: Ellen Fagan, CIGNA  
Eileen O'Connor, Health Net

Physician organizations: Scott Flinn, MD, Arch Health Partners  
Keith Redman, Desert Oasis Healthcare

At-large: Kristy Alvarez, Pacific Business Group on Health

## 2011 Timeline

Health Plans and Self-Reporting POs submit audited, locked and zipped results to DDD/NCQA	May 13
DDD/NCQA run validation checks on all files received and prepare PO reports for validation	May 13 – 24
POs review their results by measure by plan and report discrepancies to NCQA	May 24 – May 31
NCQA works with POs, plans and auditors to resolve reported discrepancies	June 1 – June 7
Preliminary results are calculated, validated and released to POs and plans	June 8 – 24
Appeals accepted and resolved	June 24 – June 30
Final results communicated to health plans	July 11
Final results communicated to POs	July 20