Integrated Healthcare Association

Align. Measure. Perform.

Questions and appeals best practices & FAQs

Updated May 2021

If you have general questions about the AMP appeals process or AMP program, please contact amp@iha.org.

To submit questions and appeals during the questions and appeals process, please submit your inquiry to appeals@iha.org.

Table of Contents

About questions and appeals

Complete and accurate results are of utmost importance for the Align. Measure. Perform. (AMP) Program. Despite a thorough validation and quality assurance process, it is possible for discrepancies to occur in the AMP preliminary results. We rely on a formal review process, the Questions and Appeals Period, to allow both participating provider organizations (POs) and health plans to request more information about their preliminary results and to request an appeal for corrections before results are finalized for the measurement year.

How does the process work?

The Questions & Appeals Period begins the day the preliminary results are released and continues for 15 business days. AMP staff review submitted questions and appeals on an ongoing basis during the 15 business day review period and communicate with submitters and partners as needed for up to 4 business days following the end of the period to research and resolve issues. Any appeals still unresolved at this time are adjudicated by an Appeals Panel composed of three health plan representatives, three PO representatives, and one at-large representative. Following deliberation by the Appeals Panel, POs and health plans who submitted an appeal are notified of the status of their appeal and any necessary follow ups, such as data resubmissions by health plans. Once this process is complete, preliminary results are finalized for use in public reporting, identification of IHA award winners, and value-based incentive payments.

We release two sets of AMP measure results per measurement year: Audited Quality Results (May) and Onpoint-Generated Results (August). The Questions & Appeals Period occur following the release of each set of results. During each Questions & Appeals Period, we ask that you review the applicable set of AMP measure results for the appropriate measurement year.

Release	AMP product lines	Measure results	Timeline
Audited Quality Results	Commercial HMO Medicare Advantage	**All Applicable Product Lines**: • Audited Clinical Quality Measures (CQM) • Advancing Care Information (ACI) • Patient Assessment Survey (PAS) • Data Quality: Encounter Rates by Service Types (ENRST) • Enrollment as of 12/31 (ENRM)	May - June
Onpoint-Generated Results	Commercial HMO Medicare Advantage Commercial ACO Medi-Cal Managed Care	**All Applicable Product Lines:** • Appropriate Resource Use (ARU) • Total Cost of Care, including service categories (TCOC) • Clinical Quality: Behavioral Health & Substance Use (COB & HDO) • Data Quality: Encounters (ENFMT & ENLAG) **Medicare Advantage Only** • Clinical Quality: Diabetes - Statin Use in Persons with Diabetes (SUPD) **Commercial ACO & Medi-Cal Managed Car**e Only • Clinical Quality Measures (CQM)	August - September

Release	AMP product lines	Measure results	Timeline
		• Data Quality: Encounter Rates by Service Types (ENRST) • Enrollment as of 12/31 (ENRM) **Medi-Cal Managed Care Only** • Patient Assessment Survey (PAS)	

Best practices for Questions and Appeals

During the 15-business day Questions & Appeals Period, we highly encourage you to thoroughly review your preliminary measure results and submit inquiries to appeals@iha.org per the guidelines outlined in the Questions & Appeals Submission Guide for the appropriate AMP release. Appeals often require significant follow up, so **please submit as early as you can** to allow time for IHA, PBGH, NCQA, Onpoint, health plans, and other data partners to research your questions. **Late appeal requests will not be accepted.**

To assist with your review, a few best practices (not exhaustive) are listed below:

1. **Identify a lead** to validate the data. Designating a single person to manage the review of your preliminary AMP results helps streamline the data investigation process.
2. **Review preliminary measure results as soon as possible** following the release of results in the IHA Analytics Portal. Google Chrome and Mozilla Firefox are the recommended web browsers when viewing your measure results in the portal. If you need portal access, please reach out to your organization's designated primary contact and/or contact us at amp@iha.org.

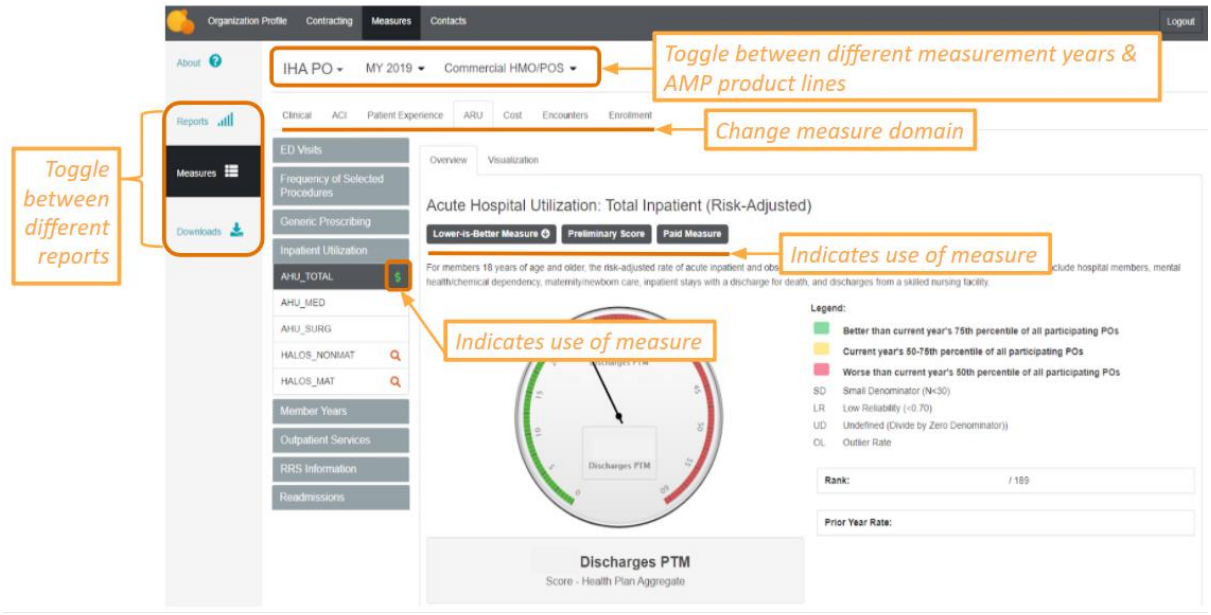

Figure 1 (above): Screenshot of the IHA Analytics Portal.

3. **Check your data for overall completeness.** You should confirm that all contracted health plans participating in the AMP program are included in your results. In addition, we recommend checking that the encounter rates by service types (ENRST) for each contracted health plan are consistent with your internal understanding.

Please note that it is the PO's responsibility to ensure the successful transmission of data to your plan partners throughout the year.

4. **Consider if the measure result is recommended for use in incentive payments and/or public reporting.** IHA recommends that you review all measures but encourages you to prioritize your review of measure results used in IHA's value-based incentive design (denoted with a $ in the sidebar of the IHA Analytics Portal), public recognition awards, or public reporting (denoted with a "public reporting" tag under the measure name).

   In addition, please note that testing measures are not subject to appeals. Before new measures are recommended for use for public recognition, incentive payments, and/or public reporting, they undergo IHA's thorough measurement adoption process, first as a testing measure (denoted with a magnifying glass icon), and then as a first-year measure (denoted with a star symbol). Since testing measures are not considered to be fully adopted into the AMP program, their measure results are not eligible for appeals. However, we highly encourage you to submit any questions about your testing measure results, as your questions may be reviewed when our technical committees vet these measures.

5. **Explore your measure results in downloadable Excel files** from IHA Analytics Portal. Below is a table delineating the files available for download and their uses.

File name	File description	How to use
Benchmarks (Quality) Benchmarks (Resource Use)	Summary statistics and percentiles by measure, domain, and product line. There are two versions, with and without Kaiser Permanente data.	Compare your performance with respect to the entire AMP population. Check for year-over-year consistency of your measure results.
Quality Results	Results for all quality measures, excluding invalid results (i.e., rates that are unreliable or do not meet the minimum denominator criteria). Includes the better of the self-reported rate and all-plan aggregate rate.	Confirm that the better of the two rates (self-reported rate vs. all-plan aggregated rate) is featured in this file. Check for year-over-year consistency of your measure results.
Unaggregated Rates (Quality) All Results (Resource Use)	Results for all quality or resource use measures. All Results (Resource Use) can include testing measures.	Compare your all-plan aggregated results against your individual plan results for each contracted health plan and, if applicable, your self-reported rates (Quality only). Check for consistency across results and year-over-year consistency of your measure results.
Quality Composite Score (Quality) Year-Over-Year Improvement (Resource Use)	Results for measures used in IHA's value-based incentive design.	Check for year-over-year consistency of your measure results that are recommended for use in calculating incentive payments.

6. **Confirm that you used the appropriate measure specifications** per the AMP Program Manual to generate internal rates used to compare against your AMP results. Criteria used to determine the eligible population include but are not limited to the following:

   a. Age

   b. Continuous enrollment and anchor date requirements and allowable gaps

   c. Benefit

d. Event/diagnosis

e. Exclusion criteria

f. Outlier criteria

7. **Compare your PO's performance across regions and against other POs that you manage.** Please check if regional similarities and differences align with your expectations. Also check that your results are consistent with previous year's rates and your internal understanding (e.g., by health plan or measure).

    a. For regional benchmarks, please reference the California Regional Healthcare Cost & Quality Atlas.

8. **Submit your inquiries and data investigation requests early to appeals@iha.org,** ideally within the first two weeks of the Questions & Appeals Period. Early submissions allow for more time for all involved parties, including IHA, NCQA, Onpoint, and health plans, to thoroughly research your inquiries before the Appeals Hearing. Evidence, supporting documentation, and screenshots are requested to substantiate a potential appeal and inform our data investigations. As a reminder, IHA does not accept protected health information (PHI); please do not include this in your submissions.

9. **Join IHA's preliminary release webinars** for more tips on reviewing your AMP measure results. Webinar dates and times will be announced through our regular program communication channels. Webinar slides and recordings will be posted on the IHA website after the event.

Reviewing Audited Quality Results: Other Considerations

1. What is considered a "valid rate" for clinical measures?

    a. A PO's plan-aggregated clinical measures results with denominators less than 30 are considered not valid results. Small denominator results are not used in Quality Composite Score calculations for incentive payments, awards, and public reporting. Please also note that a PO's self-reported results are also subject to this small denominator rule if the self-reported score is considered the final score.

    b. For commercial HMO, PO's patient experience measure results with low reliability are not considered for in Quality Composite Score calculations for incentive payments, awards, and public reporting.

2. Is the **year-over-year enrollment** aligned with my expectations?

Demographic Information	Measure Abbreviation: Measure Name	Data Source	Location in Analytics Portal
Enrollment as for 12/31 of the measurement year (point in time enrollment capture)	ENRM_HMOPOS: Enrollment: Commercial HMO/POS ENRM_MEDICARE: Enrollment: Medicare Advantage	HMO & MA: Health plan audited quality submission to TransUnion	Enrollment tab

Best Practices: Reviewing Onpoint-Generated Results

- Are the year-over-year increases or declines in performance **aligned with my internal results**? For ARU measures used in IHA's value-based incentive design, the reliability and year-over-year stability of measure

results are influenced by the size of your patient population. IHA defines "small PO" as provider organizations with fewer than 5,000 member years of commercial HMO/POS enrollment with a single plan. If you see a small PO-pooled result, it's likely that there was small membership for that result.

- How does the **risk-adjusted rate** compare to the **observed rate**? Are there any factors that may have influenced my organization's diagnoses information and/or risk scores? Have you reviewed diagnosis coding completeness for professional and facility claims and encounters information?
    - Diagnosis Coding Completeness: found under "Claims and Encounters: Diagnosis Coding Completeness (Facility)" (DX_CODING_FACILITY2) and "Claims and Encounters: Diagnosis Coding Completeness (Professional)" (DX_CODING_PROF2) on the ARU tab.
    - The risk-adjusted rates for ARU measures use the Hierarchical Condition Category (HCC) risk adjustment model. HCCs can be found under the observed-to-expected ratio for your ARU results.
    - Please note that risk adjustment model used for TCOC is different from what is applied to your ARU results. The ACG Relative Risk Score (RRS), which is normalized to each AMP population, can be found under your risk-adjusted TCOC measure results. To read your ACG RRS, note that a RRS of 1 represents the average for that particular AMP population. For example, a RRS of 1.1 for Commercial HMO is 10% higher than the average for Commercial HMO, while a RRS of 0.9 is 10% lower than the average.
- What is used for public reporting considerations for Readmissions and Cost measurement?
    - Total Cost of Care (TCOC): A PO's plan-aggregated results with denominator less than 200-member years (or 2400 member months) are not considered for public reporting only.
    - All Cause Readmissions (PCR): A PO's plan-aggregated results with denominator (index hospital stays) less than 30 are not considered for public reporting only.
- Are the patient population **demographics** (e.g., median age, gender distribution), year-over-year shifts in **enrollment**, and **member months and years** aligned with my expectations?

Demographic Information	Measure Abbreviation: Measure Name	Data Source	Location in Analytics Portal
Member characteristics such as age, gender	CLM_ENR_MBRS2: Claims and Encounters: Member Characteristics	Health plan member-level information to Onpoint health data	ARU tab
Enrollment as for 12/31 of the measurement year (point in time enrollment capture)	Enrollment column of ACO results ENRM_MEDICAID: Enrollment: Medicaid	ACO & MC: Health plan member-level information to Onpoint health data	Downloads (ACO) Enrollment tab (MC)
Medical Coverage (in member months and member years)	MBRMOS_MED: Medical Coverage Member Months MBRYRS_MED: Medical Coverage Member Years	Health plan member-level information to Onpoint health data	Cost tab
Medical and pharmacy coverage (in member months and member years)	MBRMOS_MED_RX: Medical & Pharmacy Coverage Member Months MBRYRS_MED_RX: Medical & Pharmacy Coverage Member Years	Health plan member-level information to Onpoint health data	Cost tab

5. **Dive into the member-level detail** with the secure Onpoint Member-Level Detail Portal (for Onpoint-Generated Results only). We highly recommend leveraging this resource to understand which patients were included in the numerator and denominator of your ARU measure results for the AMP Commercial HMO, Medicare Advantage, and Medi-Cal Managed Care product lines. For more information on how to log-in, please refer to the Onpoint Member-Level Detail Portal Quick Start Guide. If you experience any technical difficulties with the Onpoint Member-Level Detail Portal, please contact iha-support@onpointhealthdata.org, and an Onpoint staff member will be ready to assist you with your request.
6. Note: Onpoint portal access refreshes every measurement year for data security purposes; **you must redesignate a system administrator and user(s) before each and every preliminary Onpoint-Generated Results Release.** IHA will send reminders in our monthly AMP newsletters as we approach the release.

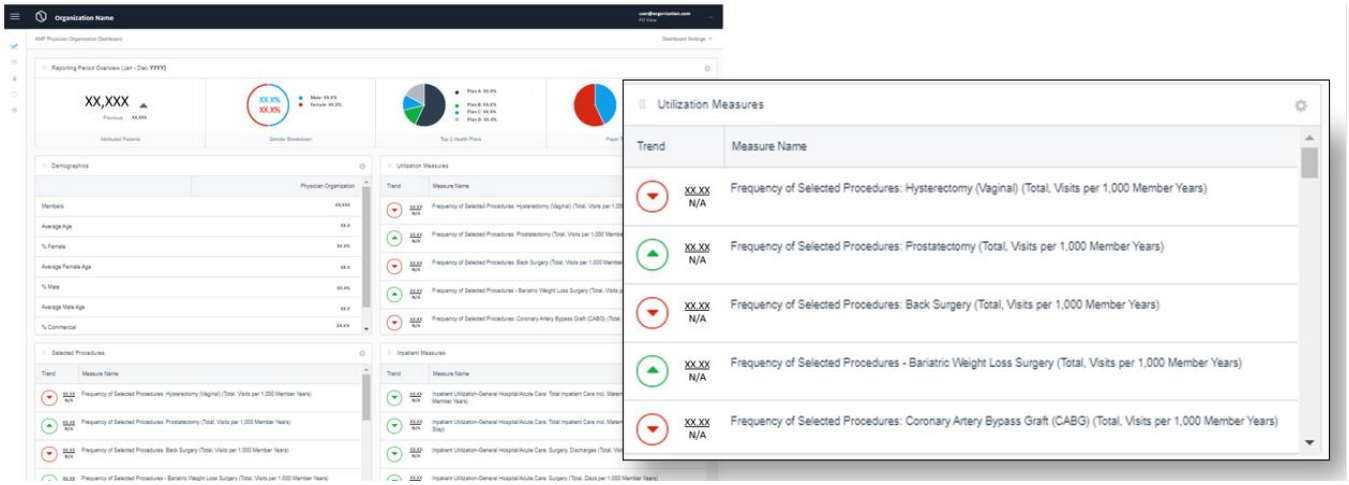

Figure 2 (above): Screenshots of the Onpoint Member-Level Detail Portal dashboard landing page.

Frequently Asked Questions (FAQ's)

To provide increased transparency around the appeals process, the following FAQ's provide examples of precedent inquiries that were elevated to the Appeals Hearing and their outcomes. Please note that the example cases described in this document are not exhaustive of all appeals investigations.

Differences between questions and appeals

Questions typically seek clarification about how a measure was generated or how to access AMP results. Any inquiries questioning the validity, accuracy, or reliability of AMP results are treated as appeals. A question can evolve into an appeal, depending on the nature of the inquiry.

Below are a few examples of commonly submitted inquiries we receive during Questions & Appeals and how we categorize them during the Questions & Appeals process:

Inquiry Topics that may be elevated to an Appeal	Inquiry Topics suitable for Questions only	Inquiry Topics NOT eligible for Questions & Appeals
PO submitted appeals relative to health plan data submission errors that reflect true, systematic reporting errors (e.g., missing a month of claims data, mistakenly duplicating membership or excluding a population for a specific contract) Health Plan or PO submitted appeals relative to data aggregation errors by IHA or IHA data partners (e.g., not applying measure specifications correctly) Health Plan or PO submitted appeals relative to auditor errors Note: each appeal must substantiate the error with evidence using either AMP data results and/or internal data results; Do not send PHI.	Measure specifications & results methodology Testing measures for all product lines Data released outside of the current Questions & Appeals Period (e.g., we can only receive questions about your audited quality results during the Audited Quality Results Questions & Appeals Period) How to access AMP results in the IHA Analytics Portal and/or Onpoint Member-Level Detail Portal (Onpoint-Generated Results only)	Requests related to missed deadlines by the PO or health plan, including those caused by its encounter intermediary or auditor Requests to resubmit isolated encounter data transmission issues, as POs are ultimately responsible for ensuring successful data transmission to their contracted health plans throughout the year Correction of self-reported data submitted by the PO (e.g., results submitted to TransUnion by your PO). Please check your submission of self-reported results to ensure its completeness and accuracy before sending files to your auditor and TransUnion. Inquiries submitted after the Questions & Appeals Period deadline; no extensions granted

Factors the Appeals Panel considers

The Appeals Panel may consider the following questions during deliberation:

- Based on AMP measure specifications, comparisons with historical AMP data and current plan/PO measurement year results, and discoveries during the appeal investigation, is there sufficient evidence to substantiate that **a true, systematic reporting error** was made by the plan, IHA, or data partner? If so, should we pursue data suppression, plan data resubmission, or a different solution?
- Is the discrepancy in question reflective of **out-of-area claims or gaps in the data exchanges** between the PO and health plan?
- **Which path forward is the best choice,** given the anticipated impacts on the AMP program timeline and downstream deliverables (e.g., public reporting, PO awards, and incentive payments)?
- **Is additional research required** by the PO, health plan, data partner, and/or IHA to make a firm decision on the appeal?

Examples of upheld appeals

Release	Appeals Description & Submitted Evidence	Investigation Findings	Panel Decision & Outcome
Preliminary Audited Quality Results	PO A submitted tables noting substantial year-over-year percent decreases by Plan 1 compared to PO A's internal rates. In plus, PO A graphically presented lower than expected enrollment numbers reported by Plan 1 compared to PO A's internal data.	After further investigation by Plan 1, it was discovered that two populations were not included in the plan's vendor software for the audited clinical quality file submission to TransUnion, which contributed to the deficit in Plan 1's enrollment numbers for PO A. Enrollment, encounters, and clinical quality measures were consequently impacted.	**Uphold appeal,** as Plan 1 made the omission. Plan 1 was instructed to resubmit auditor-locked AMP quality results, including enrollment, encounter, and clinical quality measures, for all contracted prov organizations, including PO A.
Preliminary Audited Quality Results	PO B noted that the patient experience results contained a submission error, contributing to no results. PO B requested that IHA use the PAS results from the prior measurement year, given the lack of sufficient time for fielding the survey.	A miscommunication occurred regarding the transmission and acceptance of encounter data files between PO B and PBGH, the PAS survey vendor. This led to the vendor failing to field the PAS survey on behalf of PO B.	**Uphold appeal,** as an error was made by PBGH. IHA used PO B's PAS results from the prior measurement year for AMP program purposes. The prior year's PAS results were used for attainment scoring only, as there was no way to score improvement. PO B remained eligible for AMP recognition awards. To support accurate results going forward, IHA worked with PBGH to improve their process for capturing the correct groups.
Preliminary Onpoint-Generated Results	POC submitted multiple tables noting the percent decrease in risk scores from the prior measurement year at the plan-PO level for Plan 3 in comparison to all other AMP contracted plans. PO C also noted that there was no large enrollment changes that could contribute to this risk score change.	Plan 3 discovered that a subpopulation was included in the eligibility data submission but inadvertently excluded from their medical and pharmacy claims submission, resulting in a decrease in overall risk scores for cost. The missing claims information also had a slight impact on ARU measure results.	**Uphold appeal,** as this subpopulation should have been included in all file submissions by Plan 3. Plan 3 resubmitted their medical and pharmacy claims. To ensure Plan 3's inclusion in the final release, the Appeals Panel granted IHA and Onpoint a 5-business day extension. In addition, IHA created a comparison file for PO C to review the updates to their risk scores and ARU results prior to the final release.
Preliminary Onpoint-Generated Results	PO D submitted tables displaying the observed AMP TCOC trend with Plan 4 increased much more compared to results with other plans. In addition, the PO included TCOC trends in comparison to their own internal rates. PO D evidenced that resource use did not largely increase to substantiate the TCOC increase.	IHA, Onpoint, and Plan 4's investigation surfaced an accounting error in the cost file submission to Onpoint, which resulted in the increase in the observed TCOC.	**Uphold appeal,** as the accounting error was made by Plan 4. Plan 4 resubmitted its cost file before the final release. Onpoint confirmed that the accounting error was corrected with the resubmission, and the increases in TCOC trend became more comparable with the other AMP health plan trends.

Examples of denied appeals

Release	Appeals Description & Submitted Evidence	Investigation Findings	Panel Decision & Outcome
Preliminary Audited Quality Results	PO E requests to resubmit new rates for certain quality measures.	PO E self-reported the numerators and denominators for the measures in question; this does not constitute an error on the part of IHA, health plans, or vendors.	**Maintain results and deny appeal,** as the Questions and Appeals Period is an opportunity to correct errors on the part of IHA, health plans, or vendors. Questions & Appeals is not an opportunity for POs to update or correct their own submissions.
Preliminary Audited Quality Results	PO F submitted tables showing decreases from the previous year for numerator, denominator, and rate for one of their quality measure's rates for Plan 5.	Plan 5 confirmed that per the data partner that processed PO F's data files, PO F did not submit supplemental lab data for that measure. PO F confirmed that supplemental data was provided to Plan 5 for the prior measurement year, and PO F used the plan's portal to upload their data for the current year. PO F was then informed that the portal was not intended or set-up for AMP reporting, at which time PO F implemented a separate claims process. However, in this process, it was determined that PO F was improperly coding this measure by using codes not included in the measure specifications and code sets.	**Maintain results and deny appeal,** as there was not sufficient evidence to substantiate a health plan error. The investigation suggested that reported rates were ultimately the result of incorrect coding by PO F, not an error made by Plan 5 in generating the rate. PO F also had access to the appropriate code sets to inform successful data sharing. The Appeals Panel encouraged PO F to work closely with its contracted health plans to ensure proper data sharing processes and inclusion throughout the year.
Preliminary Onpoint-Generated Results	PO G submitted a table containing current and previous year trending for numerator, denominator and rates for TCOC showing a larger than expected increase with Plan 6 compared to other AMP contracted health plan trends.	IHA results reflected increases in observed costs for Plan 6 across multiple contracts. There was also a corresponding increase in related utilization measures, especially inpatient utilization and pharmacy costs, which would contribute to a substantive portion of the cost increases. These observations corroborated with the Plan 6's findings from their internal data investigation.	**Deny appeal,** as the findings suggested by the results were inconsistent. While inpatient and pharmacy utilization trends confirmed by Plan 6 would contribute to the cost trend, contracts where utilization didn't fully explain the variation were quite small and would be expected to exhibit more unexplained variation at the plan-level. Furthermore, Plan 6's results for other POs were consistent between years. The Appeals Panel suggested PO G to investigate whether any individual tertiary or quaternary case could have contributed to the result; whether the risk agreement may inadvertently have led to less patient management; and the relative contributions of rate (price) versus volume (utilization).
Preliminary Onpoint-Generated Results	PO H submitted tables demonstrating increases in risk adjusted TCOC and an increase in the expected readmissions for	IHA and Onpoint investigated potential factors contributing to the decrease in risk-scores: membership information (enrollment count, average age, gender distribution);	**Deny appeal,** as the available information did not substantiate that an error was made by IHA, Plan 7, or Onpoint.

Release	Appeals Description & Submitted Evidence	Investigation Findings	Panel Decision & Outcome
	Plan 7 in comparison to other AMP contracted health plans.	plan 7 claims submission to Onpoint; variation in encounter rates across PO G's contracted health plans and over time; and diagnosis coding completeness on claims and encounters. IHA confirmed that the total count of claims and encounter records received by Onpoint is consistent with what is available in Plan 7's data warehouse. IHA and Onpoint analysis also confirmed that the depth of diagnosis coding appeared reasonable and that Plan 7's encounter rates as a whole improved from the prior measurement year. These findings suggest that the plan's data submission to Onpoint was complete based on the data available in-house and consistent with Plan 7's internal reporting.	The Appeals Panel thought that that variation in risk scores was likely driven by incomplete encounter data transmission, which is out-of-scope for the Onpoint-Generated Questions & Appeals. The panel also recommended that PO H and Plan 7 work together to improve encounter data transmission throughout the year. A possible alternative explanation identified by the Appeals Panel, was that the changes in risk scores reflect actual changes to PO H's population. The panel requested that IHA work with Onpoint to determine the proportion of membership that overlapped between the two years. The analysis identified a moderate overlap—roughly 70%—between the members enrolled in PO H over the pertinent two measurement years. The findings from this analysis suggest that the decline in risk scores could have been driven by population changes.

Questions?

Contact appeals@iha.org with any questions about the AMP Questions & Appeals process.