RECONSIDERATION PROCESS AND POLICY

Purpose of this document

To provide a policy and process by which medical groups, clinics, and providers may request to have their data reconsidered and recalculated. This option is available during the medical group review period that follows each new round of reports.

Background: Q Corp reporting

The Oregon Health Care Quality Corporation (Q Corp) is dedicated to improving the quality and affordability of health care in Oregon by leading community collaborations and producing unbiased information. The goal of Q Corp's measurement and reporting initiative is to improve patient care by coordinating and consolidating quality and utilization information. Q Corp creates and distributes quality and resource use reports for medical groups and providers on a quarterly basis.

Measuring the quality of health care requires a number of complicated technical decisions. Q Corp's Measurement and Reporting Committee, composed of consumers, providers, employers, policymakers and health insurers, studies measurement issues and helps to guide key decisions in this initiative.

Why would a medical group review its data and apply for reconsideration?

There are several reasons a medical group may elect to review its data and apply for reconsideration. These include:

- **Public reporting** – Following one reporting period, results for a subset of measures are posted on Q Corp's consumer website for clinics that meet Q Corp's public reporting criteria.
- **Other reporting** – Medical groups may use Q Corp measures for other reporting initiatives, including OHA Patient-Centered Primary Care Home certification program, health plan contracting, and others. Recently, Q Corp elected to add measures that align with quality and resource use measures used for Coordinated Care Organization (CCO) incentives down to the provider level. Please note that these scores are not tied to the incentive payments but do provide the ability to identify patients in need of a recommended service such as breast cancer or cervical cancer screenings.
- **Q Corp data supplier reporting** – Following each reporting period, Q Corp returns medical group, clinic and provider scores to its participating data suppliers.
- **Quality improvement** – Medical groups that use Q Corp's reports for internal quality improvement efforts may wish to review their data for accuracy.

I. Reconsideration Request Policy

Q Corp's measurement initiative uses the most widely available data source – administrative claims (billing) records – to measure patient care quality. Using only administrative claims records to measure quality can result in inaccuracies. To ensure fairness, the initiative has developed the following policy that includes a provision for reconsideration and recalculation of a clinic's results. This policy is intended to provide a fair and transparent process by:

- Establishing consistent criteria by which data will be reconsidered/recalculated;
- Providing a timely process for review;

- Focusing on improvement of quality measurement;
- Ensuring the privacy and security of patients.

Medical groups that wish to have their data formally reconsidered and their results recalculated **must enter all data corrections through Q Corp's online secure portal by the deadline** listed in report materials and posted at http://q-corp.org/reports/provider-reports.

The reconsideration process will be administered by Q Corp staff in consultation with Q Corp's Measurement and Reporting Committee and data vendor, Onpoint Health Data, as necessary. During public report rounds, if the initiative is unable to respond to requests in a timely manner it will not publish results for a clinic while reconsideration requests are pending. Instead, results for the clinic will be noted on the website as "Results Under Review."

As part of the review and reconsideration process, Q Corp will provide a clear timeframe for the medical group review period and deadline by which reconsideration feedback must be received.

Q Corp will apply consistent criteria to assess which patient-level feedback or corrections received through the secure portal will be accepted. The following are the criteria used to assess requests for reconsideration of a clinic's results:

Correction requests that will typically be accepted:

- This provider left the medical group. *Termination date requested.*
- This provider has never belonged to the medical group or clinic.
- This provider is a specialist (not a primary care provider), and therefore, shouldn't be assigned patients.
- Patient is unknown to clinic or medical group.
- Patient was not seen during the two-year attribution period (measurement year and year prior).
- Patient does not meet the specific criteria for the measure. *Additional information required.*
- Patient meets the specific criteria for the measure and DID have service. *Additional information, e.g., date of service, required.*

Correction requests that typically will not be accepted:

- Patient refused service.
- Prescription was written but not filled by patient.
- Order was given but patient did not get screening or test.
- Provider is not responsible for managing the services being measured.
- Disagreement with a measurement specification, or with the data collection process/method.
- Measurement results do not match rates or results from a medical group or clinic's internal registry (where numerators and denominators are not comparable).

IMPORTANT: To protect patient privacy, all communication about individual patients and their care must be submitted through Q Corp's secure reporting portal, accessible from the provider landing page at http://q-corp.org/reports/provider-reports. **Please do not deliver patient information directly to Q Corp staff.**

Q Corp will review all reconsideration requests and respond to the discrepancies submitted through the secure reporting portal. Corrections do not require extensive documentation by the medical group or clinic beyond a

date of service and comments. However, the initiative reserves the right to request additional documentation to verify corrections. Q Corp's response to a reconsideration request will be made within 30 days of receipt and will include:

- Decisions regarding corrections and reasons why corrections were accepted or not;
- Whether the publicly reported category will be changed;
- Request for additional information if necessary, or request to conduct an audit to verify data in the medical record.

II. Reconsideration Request Process

Medical group review period

Q Corp's reports are accessible through a secure reporting portal, allowing users to view data at the medical group, clinic, provider, and patient levels. The physicians, nurses, and medical group administrators who helped design Q Corp's measurement and reporting initiative emphasized that providing patient-level detail to medical groups is essential if claims information is to be validated, trusted, and useful.

Based on feedback from multiple medical groups that plan to use Q Corp data for other reporting initiatives – including OHA Patient-Centered Primary Care Home certification program, health plan contracting, etc. – Q Corp offers an optional medical group review period following each round of reporting, with the opportunity for medical groups to have their scores reconsidered and recalculated.

The medical group review period begins when refreshed data become available to medical groups on Q Corp's secure reporting portal. As all groups with access to the portal have an email on file, Q Corp will send an email message announcing when refreshed data are available.

Submission and review of reconsideration request

The following steps describe the reconsideration process:

A. Medical groups must submit patient-level data corrections through the secure reporting portal before review will begin. Patient information shall not be sent directly to Q Corp staff.

B. C. Q Corp's measurement staff will review feedback submitted through the secure reporting portal. Staff may call on Q Corp's data vendor, Onpoint Health Data, to provide supporting information derived from the claims database.

D. Q Corp's Informatics team will review all requests and make decisions based on the information supplied through the secure reporting portal, and supporting information from the data vendor.

E. Q Corp's Executive Director will remain informed of all requests for reconsideration.

F. Q Corp will schedule a call with the medical group contact to respond to the patient-level corrections submitted through the secure reporting portal and offer a basis for decisions made.

G. Formal notification of decisions and results of data recalculations will be communicated to the medical group via e-mail from Q Corp's Informatics team within 30 days of the deadline for submitting reconsideration requests.

    1. In rare cases where detailed verification of claims records and patient information requires longer than 30 days, Q Corp will notify the medical group with an explanation. If a request is not resolved before public data are posted, quality results for the clinic(s) will be noted on the website as "Results Under Review."

H. If the decision reported by the Senior Director of Informatics is not in the medical group's favor, the

medical group may submit a written appeal to Q Corp's Executive Director.

1. The Executive Director will determine if additional information is needed. During this process, any appellant who wishes to make a presentation to the Executive Director will be granted the opportunity to do so.
2. The Executive Director will make decisions about the dispensation of the appeal and their decision will be communicated to the medical group contact in a written letter from the Executive Director within 45 days of the appeal.
    a. Should additional expertise or review be needed, the appeal will be advanced to Q Corp's Measurement and Reporting Committee, a subcommittee of the Q Corp Board of Directors, for determination.
3. During the appeals process, quality results will be noted on the website as "Results Under Review."