

PRO Questions and Answers for the EP² National PRO Call August 28, 2001

- Q1: What is meant by H? Is it hospital or HIC #, or neither?
- A: The H number is the health plan's identification number. Each has to define its own denominator and report separately for the extra payment activity.
- Q2: Can CMS clarify if the analysis piece of this project is considered technical assistance?
- A: Yes, as clarified in the SDPS memorandum 01-152-TP, if the PRO is providing the M+CO with one or more elements that comprise a project, but not all, such as the analysis part of a project, then it is considered technical assistance.
- Q3: I also have a question for the remeasurement period of the regular QAPI CHF project. I know the baseline is 07/01/99-06/30/2001; is the remeasurement 07/01/2000-06/30/2002?
- A: This question confuses QAPI and EP. There is no remeasurement period for extra payment. QAPI projects do not have a defined baseline except that it can be any time from Jan 1, 2000 to Dec 31, 2001. The question that is posed lays out the dates for EP. The remeasurement for QAPI consists of a one year period. Theoretically for QAPI, the first year is getting the baseline (which is usually one year of data), the second year is implementing interventions and the third year is the remeasurement. So in the scenario given, the remeasurement year should be 7/01/2002 - 6/30/2003.
- Q4: When we are doing the initial measurement, if a member has had more than one hospitalization (in the same period) for CHF, do we take data from all of them or just one (and which one) for the inpatient study?
- A: For QAPI, the plan has the option of which date it wants to take to include the member in the denominator, but you only need to take one hospitalization. They must apply this criteria throughout the study population and remain consistent in the study. Because QAPI is designed for both inpatient and outpatient populations, CMS views them both as equally important. If this question is related to extra payment, you also take one of the hospitalizations. It doesn't matter for which hospitalization you abstract the data in a given time period. With respect to data collection, you may collect data from inpatient or outpatient records.
- Q5: What is "PIP"?
- A: "PIP" is shorthand for "PIP-DCG" the Principal Inpatient Diagnosis Cost Group. This is the current inpatient risk adjustment payment methodology that CMS has implemented

for paying M+COs. There are 15 PIP-DCG categories. They are groupings of inpatient diagnoses according to their costs. CHF falls into PIP-DCG 16 which includes several other diagnoses that have equivalent costs to treat. The higher the PIP-DCG, the higher the associated payments. For example, the highest PIP-DCG, PIP-DCG 29 includes AIDS and blood and lymphatic cancer (different diagnoses, but similar costs). Each PIP-DCG category carries an associated payment that a M+CO will receive based on the principal inpatient hospital discharge diagnosis that was submitted by the M+CO in the previous year.

Q6: If MCOs don't submit data to CMS for inpatient hospitalizations by 9/30/2001 for hospitalizations that occurred between 7/1/99-6/30/01 will these patients not be eligible for extra payment despite that MCOs have evidence of the hospitalization?

A: Data that is submitted to CMS by 9/07/01 for hospitalizations that occurred between 7/1/00 and 6/30/01 will be recognized for payment during 2002. However, data received after 9/30/01 and by 9/30/02 will be used for 2002 payment reconciliation which is conducted in mid 2003. If the data is submitted to CMS by 12/31/01 for hospitalizations that occurred between 7/1/99 and 6/30/00, then the M+CO will receive payment for that hospitalization during the 2002 reconciliation conducted in mid 2003.

Q7: Can a MCO submit one request in 2003 to collect extra payment for reporting year 2001 and 2003 or do you have to submit a request each year?

A: It is not clear what is meant by a "request to collect extra payment." Extra payment will not be made unless the M+CO meets its quality thresholds in the previous year. A M+CO wishing to receive extra payment must report on its numerator and denominator each year. However, a M+CO does not have to participate in both years. A M+CO can participate in 2002 only for payment in 2003 if they choose. There is no "reporting year 2003". Assume that 2003 in the question should actually be 2002.

Q8: Can evidence of LVEF testing via claims data (using suggested codes provided by CO PRO) be used as evidence for QAPI QI#1 and EP Q1#1?

A: A M+CO can certainly look at claims data for evidence of EP 1, using the suggested codes. However, in order to define the second denominator, a M+CO will need to have LVEF lab values, which would suggest needing to look at the test results, not just whether or not the test was received. For example, whether the enrollee had a lab value of less than 40% on the LVEF test is needed to know whether they have LVSD and should be included in the second denominator or not. This is also true for QAPI.

Q9: If an enrollee is identified as eligible for extra payment in 2001 can this same patient, if there was not another hospitalization that occurred from 6/2001-6/2002, be eligible for extra payment in 2002?

- A: Yes. Essentially a hospitalization for CHF between 7/1/99 and 6/30/00 can trigger a payment for 3 years. The first year of payment, 2001, the M+CO is paid under regular risk adjustment for that hospitalization. In 2002, the M+CO could receive extra payment for that hospitalization if they qualify based on meeting their quality indicators in 2001, and also in 2003, if they meet their quality indicators in 2002.
- Q10: For HF QAPI, the PRO is collecting data from reporting year 2000 on patients who were enrolled as of Dec. 2000. For the extra payment, some of these same patients will be in the denominator but some will not and the MCOs will have to collect data on these remaining patients. There will be two organizations collecting information for the EP is this acceptable?
- A: For extra payment, the M+CO may choose to work with the PRO and obtain assistance in data abstraction for extra payment, or the M+CO may perform the data abstraction itself or some combination. However, based on your question, it is not clear why the PRO could not collect all of the inpatients for the extra payment population since the extra payment population is a more narrowly drawn denominator than QAPI which includes outpatients.
- Q11: I am curious as to how the PROs that are doing the data collection have identified the primary care provider for the patient (define "primary care provider")? If patients saw both a PCP and a cardiologist during the reporting year, are medical records from both physicians being reviewed? For patients that have an inpatient and outpatient encounters that made them eligible for inclusion in the population of HF patients, are only the inpatient medical records reviewed or are inpatient and outpatient records reviewed?
- A: CMS does not specify that the CHF diagnosis must be made by a PCP for QAPI projects. A M+CO may chose to look at either inpatient or outpatient or both in order to meet the quality indicator specifications outlined in the OPL.
- Q12: There is a draft report on the website to submit for extra payment. Is the final report ready or do we use the draft? We are planning to submit our data October 1.
- A: The reporting form that was attached to Operational Policy Letter 2000.129 is pending approval by the Office of Management and Budget. CMS does not anticipate any changes to this report and is on track to receive approval of the form shortly. Note that M+COs may report this information electronically via the health plan management system (HPMS) effective October 1, 2001. Also note that in their reports to the M+CO, the PRO should use a format that will include individual-level beneficiary data, and this particular reporting form does not allow individual level reporting. Of course, a PRO can complete the reporting form for the M+CO, and report the PRO individual level data to the M+CO.

Q13: What are the performance thresholds for each of the quality indicators to qualify for the extra payment option?

A: The first, the proportion of eligible population who has evaluation of left ventricular function as of the date of reporting, should be equal to or greater than 75%.

The second, the proportion of the eligible population with left ventricular systolic dysfunction (LVSD) who 1) are prescribed ACE Inhibitors; or 2) have documented reasons for not being prescribed an ACE I, should be equal to or greater than 80%.

Q14: What if a patient is admitted more than one time during the time frame and meets the criteria for the extra payment with each admission?

A: The criteria for extra payment in 2002 is a principal inpatient hospitalization for CHF between 7/1/99 and 6/30/00. There only needs to be a single principal inpatient hospitalization for CHF and not multiple ones. You don't get extra payment for each additional admission.

Q15: In CMS' q's and a's on extra payment there is a question about whether the M+CO can exclude an enrollee from the denominator if the M+CO's physician determines that the discharge diagnosis was miscoded. The answer is that the M+CO can exclude if they provide documentation about the change in diagnosis if CMS asks for it. How does this fit into the PRO's review of the data? That is, if the PRO and the M+CO disagrees on the discharge diagnosis, can the M+CO exclude the person from the denominator?

A: It is true that if a M+CO believes there is a miscoded discharge diagnosis of CHF, they may exclude that person from the denominator. However, if the PRO is abstracting the M+COs data and does not find a discrepancy in the coded discharge diagnosis of CHF, but the M+CO excludes the person from the denominator, it will be the responsibility of the M+CO to provide the documentation for the exclusion to CMS upon request. Note that CMS will also use a PRO to verify the CHF diagnosis. If the PRO identifies a discrepancy in the coded discharge diagnosis, then CMS would accept that exclusion from the PRO without further review.

Q16: I'm confused about whether you are looking at primary or secondary diagnoses of CHF. Can you please clarify?

A: We are looking at principal inpatient discharge diagnoses only. This is stated in the Operational Policy Letter (number 2000.129).

Q17: What is the optimal time for the PRO to abstract the data? Is it before October 1 or after October 1? We don't want to do the data abstraction twice.

A: Ideally, the M+CO would sample their CHF population well before October 1 to get a sense of how close they are to meeting their threshold levels. If they are far from meeting the thresholds, they would want to allow enough time prior to October 1 to apply the quality indicators so they would have an opportunity to improve their threshold scores. If the data abstraction does not occur until after October 1, then there is no time left to intervene on behalf of beneficiaries who have not received the quality indicators. (Remember that we are measuring who has received the QI's as of October 1, not after October 1.) If a M+CO determines that they are close to meeting or above their thresholds levels, then abstracting the data after October 1 may be an acceptable approach. Remember that because of the continuous enrollment requirement, CHF enrollees who are enrolled in your plan by April 1 would be included in your denominator. For those with the continuous enrollment criteria, the latest the hospitalization can occur is June 30, 2001, so you will essentially have the denominator "set" by June 30th and know for the most part who is being managed for CHF. Only disenrollees between 4/1/01 and 10/1/01 would have to be excluded from the denominator and you won't have the final disenrollment number until after October 1.

Q18: Can administrative data such as pharmacy benefit management data be used as a sole source for measuring compliance to indicator thresholds such as ACE I utilization?

A: Before answering this question, you should be aware that we are not asking for compliance with ACE I utilization. The quality indicator is looking at the proportion of the population with LVSD who are **prescribed** ACE I, not **using** ACE I. You can use administrative data such as pharmacy data to the extent it will indicate physician prescribing rather than prescription filling. Only looking at prescriptions filled will not tell you about those who received a prescription, but did not fill it. Therefore, using administrative data solely may not be practical and may need to be supplemented by other data sources, such as medical records.

Q19: Is the M+CO expected to provide beneficiary level, patient-specific information for the numerator and denominator for each indicator upon request for auditing? Also, when the PRO reports to the M+CO, I understand they must report beneficiary-level, patient specific information. Is that correct? In the case of a PRO providing beneficiary level information to the M+CO, is there a minimum number (like 3 or 5...) of patients established such that we are not identifying exactly which patients are included in their aggregate results?

A: On the first part of your question, yes, the M+CO is expected to provide beneficiary level, patient-specific information for the numerator and denominator for each indicator upon request for auditing. On the second part of your question, you are correct. The PRO will need to provide individual level results back to the M+CO. On the last part of your question, because the PRO is providing individual level results to the M+CO, there is

no minimum number of enrollees. The PRO should report on all enrollees for whom they abstracted the data.

Q20: In the case of a M+CO audit, what proof is required for a hospitalization? Do you need an actual cover sheet or can a list from querying their system with a CHF diagnosis suffice as proof of hospitalization?

A: In the case of a M+CO being audited for CHF, they will need to furnish at a minimum an actual cover sheet from the medical record as proof of the hospitalization. CMS may request additional supporting records if the cover sheet fails to confirm the CHF inpatient discharge diagnosis. A list querying their system for a CHF diagnosis will not suffice as proof of hospitalization.

Q21: When the EP specification talks of a "greater than one day stay", do we have a formal definition of what a day is? (e.g. same as HEDIS?)

A: The definition of greater than one-day stay is the "from date" minus the "through date." If the result is greater than one, then it would be a greater than one-day stay.

Q22: For EP, if an enrollee was hospitalized during the review period but was not yet enrolled in the M+CO where he/she now resides, the OPL indicates that HCFA will 'flag' these charts in the monthly Medicare reports. The plans are concerned that they would not have access to previous hospitalization info if it occurred before the patient was their member.

A: CMS has been flagging CHF inpatient discharge diagnoses that it has received from FFS or other M+COs in the Monthly Membership Report (MMR) and will begin flagging CHF enrollees via the health plan management system (HPMS) shortly. If a M+CO wants access to an enrollee's medical record (s) they may obtain those records from the enrollee's previous providers, after enrollment in the M+CO takes place.

Q23: Can the same 411 cases be used for both QAPI and Extra Payment?

A: If the 411 are strictly inpatients hospitalized with a discharge diagnosis of CHF between 7/1/99 and 6/30/01 with a greater than one-day stay then they would be part of the EP population. However, for QAPI, you must include both inpatients and outpatients so 411 inpatients only would not fit the QAPI population criteria.

Q24: What exactly is the M+CO-designated time period? I am confused by whether this is the time period from which the population is to be determined or the time period for evaluating the quality indicators.

A: For QAPI, the M+CO-designated time period is the exact same one-year time period that is selected by the plan for determining their QAPI population. This period may be any consecutive 12-month period from 1/1/2000 through 12/21/2001.

For EP, there is no "M+CO-designated time period." For payment in 2002, the population is drawn from those patients discharged between 7/1/99 and 6/30/2001. M+COs may begin managing their CHF patients anytime after January 1, 2001. The quality indicator measurement date is October 1.

The following table should help clarify the date specifications for both QAPI and EP.

| | QAPI | EP 2001 | EP 2002 |
|---|---|---|---|
| Time period for determining population | Any consecutive 12-month period from 1/1/2000 through 12/21/2001. | Patients discharged between 7/1/1999 and 6/30/2001. | Patients discharged between 7/1/1999 and 6/30/2002. |
| M+CO-designated time period | Any consecutive 12-month period from 1/1/2000 through 12/21/2001 (Note: must be SAME 12-month period used for determining population) | N/A. For payment in 2002, the population is drawn from those discharged between 7/1/99 and 6/30/2001. M+COs may begin managing their CHF patients anytime after January 1, 2001. The quality indicator measurement date is October 1 of 2001. | N/A. For payment in 2003, the population is drawn from those discharged between 7/1/99 and 6/30/2002. M+COs may begin managing their CHF patients anytime after January 1, 2001. The quality indicator measurement date is October 1 of 2002. |
| Quality Indicator #1: LVF Assessment | Any time prior to the end date of 12-month period used for determining population. | Any time prior to 10/1/2001. | Any time prior to 10/1/2002. |
| Quality Indicator #2: ACEI prescribed or documented reason for not prescribing | Any consecutive 12-month period from 1/1/2000 through 12/21/2001. (Note: must be SAME 12-month period used | 10/1/2000 to 10/1/2001 | 10/1/2001 to 10/1/2002 |

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| | for determining population) | | |
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Q25: In the MedQuest module, it does not allow me to enter an x for a variable I am not collecting even though the help instructs me to do this.

A: For all variables that should have an "X" entered for them, you must enter a capital X (Shift x) as opposed to a lowercase x. In the clinical help whenever you see "X" this refers to a capital X (Shift x).

Q26: In the MedQuest module there are certain times when I receive a warning message after I enter a value. What should I do if my answer is correct, yet I still receive a warning?

A: Several warning edits were set in this module to help the abstractor. These warnings do not prohibit you from entering the value for which you are receiving the warning. They are only intended to alert the abstractor of possible out-of-range values. To enter the value for which you received the warning, simply click on the "cancel" button that appears with the warning. The "retry" button returns you to the value for which you received the warning.

Q27: For Extra Payment, we are planning on collecting last date of ACE Rx on our QAPI tool (reviewing year 2000). If a patient is not on an ACE-I and there is documented reason for not being on an ACE, does it have to be within period of 10/2000-10/2001 to be acceptable for EP?

A: It depends on the reason for not being on ACE I. There are contraindications to ACE I that are permanent and some that are transitory. If there are permanent contraindications, it can be documented before the 10/1/2000 to 10/1/2001 timeframe. Please refer to the May 2001 EP measurement specifications for the timeframes for the various contraindications to ACE I. This question was also addressed in the posted sets of Q's and A's on the CMS CHF website.

Q28: What are the resources for the PROs for questions outside of HF QAPI? I am getting some questions about CAHPS and know a lot about it. Where do I get information on CAHPS?

A: Please forward those questions to Kathy Winchester. I will ensure that the questions are answered.

Q29: Do we include in the population members who are in nursing homes, in hospice or who have a terminal illness but may not be in hospice?

A: The nursing home and hospice populations are not exclusions. The only exclusion is documentation that the patient was on renal dialysis anytime during the M+CO designated time period.