

Responses to Issues Raised on the July 11, 2002 National Call on the M+C Organization Congestive Heart Failure Extra Payment Activity for 2002

On the national call held on July 11, 2002, several issues were raised about the Congestive Heart Failure (CHF) Extra Payment Activity for 2002. CMS' responses are as follows:

Reassessing Left Ventricular (LV) Function in 2002

As mentioned in previous communications, CMS is not changing the measurement specifications for the second and final year (2002) of the CHF extra payment activity. Therefore, the left ventricular ejection fraction (LVEF) test to assess LV functioning may have been performed anytime in the past and does not require a reassessment. However, if a M+C organization's physician is disease managing an enrollee with a prior principal inpatient hospitalization for CHF (7/1/99-6/30/02) and wants to reassess that enrollee because he/she has reason to believe there has been a change in LV functioning (above or below 40%) it would be appropriate to include the reassessment and resulting LVSD (or not) in the results for the extra payment activity. Even if there has been a reassessment and a change in LVSD found, but the plan wants to report the old LVEF test, then they may do so. If the change in LVSD is in the positive direction (e.g. greater than 40%) and a prescription of ACE I would no longer be required for this study, then all the M+C organization needs to do is document why the person has not been prescribed an ACE I (e.g. because they no longer have LVSD). Remember that the numerator for the second quality indicator is those with LVSD prescribed an ACE I or with a contraindication to ACE I.

Using HPMS/MMR to Determine the CHF Denominator

As described in Q & A 13, posted on June 7th, M+COs should use the Health Plan Management System (HPMS) for quarterly-updated HIC-level listings of CHF enrollees in their M+C organization to assist in determining the denominator. However, effective with the June 30, 2002 quarterly updating of these HPMS data, the CHF HICs between July 1, 1999 and June 30, 2000 have been removed from this data base because there will be no future updating of the data for that year. M+C organizations therefore should refer to the CHF flag on their enrollee's monthly membership report (MMR) for that period of time (7/1/99-6/30/00) since those data are reconciled and final, and use HPMS for all other CHF level HICs for the 7/1/00-6/30/02 timeframe.

Calculating the Enhanced Extra Payment for 2003

As announced on the calls with M+C organizations, to determine the amount of extra payment a qualified M+C Organization would receive in 2003 per enrollee with a CHF inpatient discharge diagnosis between 7/1/99 and 6/30/01, the M+C organization first needs to determine the risk adjusted county payment amount. The risk adjusted county payment amounts are listed on the website at <http://www.cms.hhs.gov/healthplans/rates/2003-states/>

Multiply the risk adjusted county rate times two-thirds (.66) times the PIP-DCG CHF risk factor (2.438), times 10% (the risk adjustment phase-in amount). This gives you the monthly extra payment. For example, the county rate in Howard County, Maryland is \$617.06 per month. Multiply \$617.06 times .66 times 2.438 times .10. The extra payment is therefore \$99.29 per month per enrollee or \$1,191.47 per year per CHF enrollee in Howard County Maryland in 2003. This extra payment amount is added to the regular base payment amount for that enrollee.

The extra payment cohort is comprised of those with a CHF discharge diagnosis between 7/1/99 and 6/30/01. Therefore, for a hospitalization for CHF in either 99-00 or 00-01 or both years 99-00 or 00-01, a qualifying M+C Organization would receive a single CHF extra payment amount at the 10% phase-in in 2003.

If the hospitalization for CHF occurred only between 7/1/01-6/30/02, the M+C organization would be paid the regular risk adjustment amount in 2003 at the 10% phase-in level and not the extra payment amount. If there is an enrollee who has the qualifying inpatient hospitalization for CHF in either 99-00 or 00-01 and also in 01-02 the regular risk adjusted payment would be made at the 10% phase-in level unless the discharge diagnosis in 01-02 is less than a PIP-DCG 12. Then the extra payment amount would be paid since it would be the greater of the two payments (extra payment or regular risk adjustment).

Data Abstraction Tools for M+C Organizations

There are several options available for data abstraction tools for M+C Organizations that choose to perform data abstraction themselves for the CHF population in 2002. These options are available on the CHF website at: <http://cms.hhs.gov/healthplans/chf/>. A paper data abstraction tool and instructions are posted as well as MedQuest, an electronic data abstraction tool. In addition, two analyzers (SAS or Visual Basic) are available to M+C organizations to analyze the data that is abstracted for them by the Clinical Data Abstraction Centers. (CDACs). They are also available on the CHF website.

Contracting with Quality Improvement Organizations

One conference call participant asked whether it is possible for M+C Organizations to privately contract with a Quality Improvement Organization (QIO) for the purpose of providing data abstraction assistance for the CHF extra payment activity. CMS' response is that M+C organizations may contract with QIOs separately for the CHF extra payment activity in 2002. Data for QIO abstracted beneficiaries would be considered "verified" in the event the M+C Organization were chosen for an audit. Note however, that the QIO would have to perform the data abstraction (not simply "sign off" on an abstraction done by a plan). Also, the M+C organization should obtain individual level data back from the QIO, not just aggregated data in case CMS wants to see individual level findings at a later point in time. Finally, the M+CO and QIO should follow the necessary Medicare beneficiary confidentiality protections.

Informing Providers about Data Collection

As requested on the July 11th call, CMS has posted a “Letter to Providers” at <http://cms.hhs.gov/healthplans/chf> that M+C organizations may use to inform their providers of the need to collect required data for the CHF extra payment activity.

Contracting with Clinical Data Abstraction Centers (CDACs)

The CDACS are available to assist M+C organizations that request data abstraction services in 2002 on a first-come, first-served basis. M+C organizations should refer to information on CDAC assistance contained in the questions and answers posted with the June 7, 2002 letter from CMS regarding CHF in 2002 at <http://cms.hhs.gov/healthplans/chf>. Additional information on CDACS may be found at <http://www.cms.hhs.gov/qio/5.asp>. In addition, the CDACS have prepared the following information for M+C organizations interested in data abstraction services for CHF extra payment:

Using the CDACs’ Services For your Extra Payment Abstraction

Procedures for M+C Organizations seeking data abstraction services from the CDACs in support of the CHF Extra Payment program are outlined below:

- 1. Project Definition Call:** After you contact the CDAC, we will set up a conference call with you to discuss the details of your abstraction project, such as contact information at your organization, your expected sample size and the time line for abstraction of your records.
- 2. Sample Creation and Transmittal:** The CDAC will provide an MS Access database in which your sample information will be entered for electronic transmittal to the CDAC. The specific procedures for secure delivery of this information will be discussed during your project definition call.
- 3. Record Request:** The CDAC will generate a request letter and a pull list, as well as a bar-coded cover sheet for each record to be abstracted and will forward this to our point of contact at your organization. You will be responsible for obtaining the records, matching them to their individual cover sheets and shipping them to the CDAC. If you use the CDAC FedEx air bills that will be included with the request to ship us your records, the shipping costs will be paid by the CDAC. You will be reimbursed at a rate of \$ 0.06 per page for photocopying.
- 4. Record Handling and Storage:** The status and location of each record is continuously monitored in our tracking system through use of the unique barcodes on

each record's cover sheet. Records will be stored in a secure location for 120 days after completion of data abstraction with access limited to designated staff only.

5. **Abstraction:** The CDAC can review any source you send us, including inpatient or outpatient records, administrative data, pharmacy records, etc. However, if you plan to use any combination of sources, they must all be bundled together into a single record and matched up with their cover sheets prior to shipping to the CDAC. The CDAC also cannot accept electronic data or compiled data that is not from a source document for these reviews.
6. **Data Quality:** The CDACs have abstracted over a million records each during our nearly eight years of operation and have achieved an overall accuracy rate of over 96%. CDAC abstractors undergo a rigorous training process before beginning abstraction of any new project. The CDAC also conducts extensive Internal Quality Control activities, both formal and informal, to ensure the quality of the data delivered to you. The IQC procedures to be followed by the CDACs for the Heart Failure Extra Payment abstraction have been reviewed and approved by CMS. On-going training and help with questions is also provided to the abstractors throughout the production phase of a project.
7. **Delivery of Data:** During your project definition call we will discuss your data delivery requirements and agree upon a timeline for receipt of records and final delivery of the data. We are aware that your reports to CMS are due no later than 2/28/03. The data will be delivered to you in the form of an MS Access database. The process for secure delivery of the data will also be discussed.
8. **Additional Information:** Please contact Melanie Shahriary at the AdvanceMed CDAC [Phone: 410-964-9117 or E-mail: advancemed.mshahria@sdps.org] or Jeff Floyd at the DynKePRO CDAC [Phone: 717-767-7415 or E-mail: floydj@dynkepro.com] for further information or to request abstraction services.

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