Non-claims based Measures Live Webinar Question and Answer Log
Questions submitted on July 10, 2015

Q 1: Are these measures due for the July 31, 2015 report?

A: No, these measures are for the DY1 period ending 12/31/15. The 7/31/15 report is for the Project Implementation Plans/First Quarterly Report.

Q 2: What is the role of a medical record reviewer (and vendor) for the lab value-metrics (e.g. Viral Load)?

A: Wherever possible DOH (OQPS) will look to leverage existing data sources. For example, Childhood Immunization Status (CIS) may be possible to meet compliance standards with Medicaid Data Warehouse data. The medical record reviewer will be responsible for using the information in the medical record for the lab result. The medical record vendor will not be interacting with labs for test results that are not included in the records.

Q 3: Slide 9 of the presentation seems to include the soon to be retired Cholesterol Management measure? I thought you said that would be retired and replaced by a non-medical record measure (claims etc).

A: Yes, the Cholesterol Management measure will be retired by DOH. We are awaiting CMS acceptance of the revised metric specification guide that will address the process for replacement measures when items are retired.

Q 4: How did you arrive at the number of medical charts to review by PPS? We would like to see a detailed description.

A: The NYS DOH, Office of Quality and Patient Safety (OQPS) has suggested that a vendor conduct a random sample medical record review of these non-claims based measures for the Department. For each measure there must be a random sample generated using a 5% confidence interval and a 10% oversample (sample of 423 per measure per PPS). There are 82 unique measures required across the 25 PPSs for P4P reporting. Several measures use the same sample, so there are only 74 actual samples (for the prenatal project the 5 measures equal only 2 samples). So the requirement based on the DSRIP projects selected and the range of measures will be 423 to 2,115 per PPS. Overall we will need to sample 31,302 records (74 * 423 = 31,302).

Q 5: How does a PPS know which providers need to complete the UAS? And for which Medicaid beneficiaries?

A: The PPS will determine what providers and members are included in their project plan. THe PPS should determine what providers in the network currently conduct UAS-NY assessments and what estimated portion of the project participants involved in Palliative Care are not involved in a long-term care program. Members in long term care programs will have UAS_NY assessments which can be used for DSRIP. The PPS will need to determine how to conduct the assessments for the expanded population. The assessments for the expanded population could be done using the UAS-NY agencies in their network or have staff complete training to conduct assessments.

Q 6: For the non-MLTC population of patients, is the expectation that PPSs administer the full UAS assessment within the primary care setting as part of the clinic's palliative care protocols for engaged patients, or separately within the home?

A: The UAS-NY assessments are conducted in the home environment and generally take a few hours to complete. These would not be completed in the providers' offices. Assessments are required for the members every six months, consistent with all UAS_NY assessments in the long term care programs. Yes, the process in place requires a full UAS assessment within the primary care setting.

Q 7: For the UAS measures, given the significant training (~40 hours) requirements for administering the UAS as well as the extensive nature (1-2 hours) of the assessment itself, is the Department considering alternatives to collecting these measures for the non-MLTC population? These data collection requirements may make it not-feasible to engage non-MLTC patients in a palliative care projects for a typical primary care practice.

A: The baseline and measurement year 1 results were based on the long term care program populations. It is possible the same parameters could be used throughout the demonstration. A primary consideration is the degree to which the long term care population reflects the project group and could be used to evaluate improvement. If there are suggestions for alternative approaches, you could suggest ideas to the DSRIP BML. For the PPSs using the nursing home project for Palliative Care, the limitation to the long term care population may not be adequately reflect the project population to monitor improvement.

Q 8: As measures become P4R from P4P - does that not change the portion of DSRIP funds that are split between those two types of payments?

A: No, DSRIP funds split between P4R and P4P will remain the same. CMS would need to agree to any changes between the P4R and P4P identified in Attachment I of the Waiver Standard Terms and Conditions (STCs).

Q 9: Where can we receive copies of webinar if we didn't receive e-mail earlier in the week?

A:https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/preparation_for_data_collection.pdf

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Q 10: If these measures are due for the July 31, 2015 report, where should the PPS input their values of these measures?

A: No, these measures are for the DY1 period ending 12/31/15. The 7/31/15 report is for the implementation plan.

Q 11: On MRR, please clarify if DOH is responsible for the MRR and PPS are only responsible for supporting for the 5-year period?

A: The State will be working through a single vendor to manage and implement the MRR

process in DY1. The state will look for PPSs to identify staff that will provide ownership of the MRR process throughout the 5 years of the DSRIP waiver period. This will include key personnel in charge of PPS network management, personnel to train on the record collection process with the MRR vendor(s), and on-going support and cooperation with the MRR data collection.

Q 12: Use of primary and preventative care services and ED use by uninsured; is this still a PPS reporting requirement? If so, when is the reporting deadline? Can the Primary and Preventative care services data come from salient data?

A: The ED use by the Uninsured will be calculated by NYS DOH using the Medicaid Data Warehouse data. No further reporting is necessary from the PPSs on this measure.

Q 13: With training dates yet to be determined for 2.d.i, will PPSs be given latitude in terms of speed and scale, especially for DY1 Q2?

A: Speed and Scale is an independent measure than the items defined by the PPSs for 2.d.i discussed during the webinar. PAM and C&G CAHPS for the Uninsured are metrics as defined in Attachment J of the Waiver and in the Metric Specification guide. DOH will work with CMS to hopefully convert these measures to P4R.

Q 14: Is the PPS or DOH responsible for identifying a Medical Records Review Collection vendor?

A: DOH will work with the PPS to identify the appropriate vendor for the MRR collection process. Our hope is that the PPS has a vendor in mind that knows their organization and can assist with record collection.

Q 15: During the all-PPS meeting, NYS indicated that it would possibly allow PPSs to submit alternative data for certain measures. Is this something that is still being considered? For example, our PPS members collect info about flu shots in the EHR, would it be possible to submit this info as a supplement to the CAPHS results, particularly if the results are different?

A: No, the measures have been certified by CMS and DOH cannot deviate from the measures identified without agreement from CMS.

Q 16: For 2di - you mentioned that some of the measures may be changing form P4P to P4R - can you clarify on that one more time?

A: PAM and C&G CAHPS for the Uninsured are metrics as defined in Attachment J of the Waiver and in the Metric Specification guide. DOH will work with CMS to hopefully convert these measures to P4R.

Q 17: Are the following items the responsibility of DOH vendor or PPS?

a. determining which physician offices have these patient records
b. collecting patient records from the provider offices
c. overseeing the development of the member detail file
d. entering the data into the DOH tool for secure file submission
e. medical record review and entry quality

A: Answer provided above in **Q 11:** and **Q 14:**

Q: On Project 2.d.i, please clarify if PAM activation is P4R not P4P for the three population: NU, LU and Uninsured? You only mentioned the Uninsured population in your presentation.

A: PAM and C&G CAHPS for the Uninsured are metrics as defined in Attachment J of the Waiver and in the Metric Specification guide. DOH will work with CMS to hopefully convert these measures to P4R.

Q 18: If the Cholesterol Management measure is removed from the sample wouldn't the sample size be smaller then?

A: Yes, if CMS approves the removal of the Cholesterol Management measure, the state will have a smaller number of records in the sample and will be working to update the list soon.

Q 19: How will the state coordinate CAHPS administration with organizations / facilities that already administer CAHPS with a different vendor?

A: Hospitals conduct H-CAHPS, which a different survey instrument. The state administered C&G CAHPS is for a different purpose and with a different cohort. There is no need to coordinate as the survey administration and results are independent.

Q 20: We are a PPS with multiple hospitals, FQHC's etc. What is the process for our staff to determine which charts will be selected by provider?

A: Because the PPS contracts and Opt-Out letters will not be finalized until the Fall 2015 the state has agreed to have a single vendor run the MRR collection process. The vendor will work with the providers in the PPS network to define the individuals necessary for MRR collection.

Q 21: Please clarify: You just said that these measures are not due in July but earlier stated that 3.f.i EED data is due via July 31.

A: The Early Elective Delivery (EED) data for all months of Measurement Year 1 (July 1, 2014 - June 30, 2015) are due by December 1, 2015. Prospective data collection for measurement year 2 (started July 1, 2015-June 30, 2016) data will be submitted monthly through the HCS system. Data for Measurement Year 2 is due no later than the last Wednesday of each subsequent month. For instance, July 2015 EED data will need to be submitted on the last Wednesday of August 2015.

Q 22: Can you clarify what you mean by PAM training, is this for administration of PAM or for PPS leads/ staff in PAM tracking system?

A: The PAM training is for PPSs to understand the methodology and process for PAM implementation. This will impact expectations and workflow for the PPSs.

Q 23: Are the slides going to be available for download?

A: Yes, see here -

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/preparation_for_data_collection.pdf

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Q 24: Will the PPS need to establish their own process for counting actively engaged for 2aii? The count is based on primary and preventive services codes and we need to know if we will be required to generate the count from our data stream, or if DOH will provide it.

A: The 2.a.ii actively engaged count will be driven from claims and encounter data in the MDW.

~~**Q 25:** Is a medical record review vendor required for metrics that are currently structured data~~ (e.g. Viral Loads) and a PPS could submit on its own behalf?

A: The MRR vendors will need to collect the following measures; Screening for Clinical Depression and Follow-Up (SCD), Controlling High Blood Pressure (CBP), Comprehensive Diabetes Care (CDC), Viral Load Suppression (VLS), Prenatal and Post-Partum Care (PPC), Frequency of Ongoing Prenatal Care (81% or more), Childhood Immunization Status (CIS), Lead Screening in Children (LSC) .

Q 26: Year 1, will the member detail file will be a paper tool?

A: TBD – the validation vendor (iPro) will work to define a process.

Q 27: There are some metrics based on H-CAHPS. Will the State also send HCAHPS surveys if hospitals already do this?

A: No, the state will not be conducting H-CAHPS. H-CAHPS data that hospitals submit to CMS will be used for the results for measures using H-CAHPS as the source. It is the same hospital data used for DSRIP measures.

Q 28: the specification for the controlling high blood pressure as written in measure guide differs from the NQF spec... Your measure includes diabetics and a different cutoff.. Please advise.

A: DSRIP specifications will follow the measure steward rather than NQF. NQF reviews and modifies measures throughout the year. For DSRIP we will follow the measure steward and incorporate annual updates prior to the start of a new measurement year.

Q 29: You mentioned that will be training in PAM methodology and tying to dollars, when will this be?

A: July 2015

Q 30: will the PPS staff trained for record review abstraction be supporting the DOH vendor.

A: Yes, as a partner in the process.

Q 31: Just to confirm th ED Use by Uninsured and Use of Primary and Preventative Care Services will not be a PPS reporting responsibility

A: Yes, that measure will be extracted from the MDW.

Q 32: In the current presentation the DM component is outdated

A: The LDL-c control measure and the LDL-c testing component in the diabetes testing composite have been included in the request to CMS to remove these measures. If CMS approves the request, two of the measures associated with the Diabetes project will also be affected. The LDL-c control will be removed, and the testing component will be removed for the testing composite measure. The final manual will reflect all approved changes for cholesterol.