Ontario

Ministry of Health

Non-Cardiac Vascular QBP Expansion Initiative: Frequently Asked Questions

Version 2 – May 2021

This document was prepared in partnership with CorHealth Ontario.

Table of Contents

Purpose and Timing 5

1. What is the NCV QBP Expansion Initiative? 5

2. What changes can hospitals expect during this Initiative? 6

3. What are the benefits of this initiative? 7

4. Does this mean that outpatient procedures are now included in the NCV QBP, effective FY 2020-21? 8

5. Who in my organization should be aware of this policy change? 9

Reporting Requirements 10

6. What is the current data gap? 10

7. What are the data collection and reporting requirements of this initiative/policy change? 10

8. Is there a recommended Management Information System (MIS) Functional Centre under which same day (outpatient) vascular procedures performed in the IR suite should be coded? 11

9. When will the QBP Volume Tool be updated to include NACRS LEOD or AA volumes as outlined in the updated NCV QBP Clinical Handbooks? 12

10. When we code our AA and LEOD procedures performed in IR suites into NACRS, should we include only elective procedures (per the current QBP Definition) or all procedures (including urgent/emergent procedures)? 12

11. Are hospitals expected to implement the anticipated coding changes for AA and LEOD procedures in FYs 2020-21 and 2021-22? 13

12. Do repair procedures to correct a complication of an index procedure qualify for NCV QBP funding? 13

Funding Considerations 15

13. Are there implications to changing funding policies for the NCV QBP without a corresponding change in funding or volumes? 15

14. Are hospitals able to reallocate funding from other QBPs to cover outpatient AA and LEOD procedures until the formal carve-out in FY 2022-23? 16

15. When we take outpatient AA and LEOD procedures into account, our hospital over-performs our inpatient NCV QBP volumes. Will the ministry provide additional funding for outpatient AA and LEOD procedures? 16

16. When we take outpatient AA and LEOD procedures into account, our hospital over-performs our inpatient NCV QBP volumes. Can we net over-performance from outpatient AA and LEOD procedures against under-performance in other QBPs? 17

17. If FY 2020-21 data will be used for the carve-out, how will the impact of COVID-19 be considered? 17

18. Will there be any financial compensation for hospitals to support the coding requirements related to this policy change? 18

19. Once the carve-out happens in FY 2022-23, will inpatient and outpatient funding be blended or in separate funding lines? 18

20. Hospitals in high-volume growth areas have already increased outpatient AA and LEOD volumes without a matching growth in global funding. If the carve-out is based on FY 2020-21 volumes, is there a risk of carving-out unfunded dollars? 18

21. For FY 2020-21, can QBP funding be used retrospectively for outpatient AA and LEOD procedures? 18

22. Does the NCV QBP only include OHIP procedures? 19

General Enquiries 20

23. Who can I contact if I have questions? ... 20

Purpose and Timing

1. What is the NCV QBP Expansion Initiative?

The Non-Cardiac Vascular (NCV) Quality-Based Procedure (QBP) excludes same day (outpatient) and urgent/emergent procedures for Elective Aortic Aneurysm (AA) Repair and Elective Repair of Lower Extremity Occlusive Disease (LEOD) as well as advanced AA procedures. CorHealth Ontario (CorHealth) advised the Ministry of Health (ministry) that this creates vascular funding fragmentation and misalignment between funding and the evolution towards minimally invasive technology. The expansion would set the right foundation towards a population-based approach of service provision for patients with vascular disease in Ontario.

The NCV QBP Expansion Initiative aims to enhance the QBP in a phased approach:

- Phase 1: Aims to address the evolution of care through expansion of the NCV QBP Clinical Handbooks (both AA and LEOD) to include same day (outpatient) procedures and provide hospitals with flexibility to use inpatient QBP funding for outpatient procedures starting in fiscal year (FY) 2020-21; the goal is to advance the uptake of minimally invasive and same day procedures in Ontario to help relieve pressures on hospital inpatient resources that have become even more constrained during the COVID-19 pandemic and contribute to the efforts to end hallway medicine in Ontario.
- Phase 2: Aims to address urgency through new NCV QBP subgroups for urgent/emergent AA and LEOD procedures as well as advanced AA procedures starting in FY 2022-23; the goal is to include elective and urgent/emergent AA and LEOD procedures in the QBP program as well as advanced AA procedures. In this phase, a formal carve-out and price would be established for outpatient and urgent/emergent AA and LEOD procedures as well as advanced AA procedures. In addition, formal NCV QBP Definitions would be updated and/or created. This will allow for greater visibility into the management of AA and LEOD procedures across the province. In addition, this expansion sets the right foundation towards a population-based approach of service provision for patients with vascular disease in Ontario.

2. What changes can hospitals expect during this Initiative?

The Vascular QBP Expansion Initiative will include the following Phase 1 and Phase 2 activities:

Activity	Phase 1 (2020-21 and 2021-22)	Phase 2 (2022-23 and beyond)
QBP Clinical Handbooks	• Update NCV QBP Clinical Handbooks (AA & LEOD) to include outpatient procedures (complete)	• Update NCV QBP Clinical Handbooks (AA & LEOD) to include urgent/ emergent and advanced (AA) procedures
QBP Funding	• Provide hospitals with flexibility to use inpatient QBP funding for outpatient procedures (underway) • No recovery of funds for inpatient QBP volumes not completed during first two years of implementation (i.e., FYs 2020-21 and 2021-22) (underway) • No changes to pricing or carve-out in this initial phase	• Establish carve-out and price for: o Outpatient AA and LEOD procedures o Urgent/emergent AA and LEOD procedures o Advanced AA procedures • Update QBP Definitions for Ontario Health (OH) Region-Managed QBPs (i.e., definitions used for funding)

Data Collection / Reporting Requirements	• Vascular Interventional Radiology (IR) Current State Survey (complete) • Mandatory reporting of same day IR suite procedures into the National Ambulatory Care Reporting System (NACRS) starting in FY 2020-21 (with a deadline of May 31, 2021) (underway)	• Continued reporting of same day vascular volumes in NACRS to support QBP volume management

3. What are the benefits of this initiative?

The potential benefits/outcomes of the NCV QBP Expansion Initiative include the following:

Area of Impact	Benefits/outcomes
Financial flexibility	• Provide immediate flexibility to hospitals to use inpatient QBP funding for outpatient activity
Population health	• Promote the provision of appropriate care for vascular patients and increased flexibility in care settings • Reduce fragmentation and ensure consistent management of LEOD revascularization and AA repair procedures • Set the right foundation towards a population-based approach of service provision for patients with vascular disease in Ontario

Evidence of care	• Align with the evolving evidence that includes individualized treatment approaches based on patient and disease characteristics and patient preference • Eliminate unnecessary hospital inpatient admissions (in order to quality for QBP funding)
Per capita cost	• Align with the evolving evidence to shift vascular care towards same day and minimally invasive modalities, creating opportunities to optimize value for money
COVID-19 Response	• Support hospitals in responding to COVID-19 by allowing hospitals to treat more patients on an outpatient basis, thus freeing up valuable resources to address the surgical backlog due to COVID-19

4. Does this mean that outpatient procedures are now included in the NCV QBP, effective FY 2020-21?

No, the NCV QBP has not yet been formally updated to include outpatient procedures. Effective FY 2020-21, hospitals can use inpatient NCV QBP funding for outpatient procedures. The expansion is being implemented in two phases:

- In Phase 1 (FYs 2020-21 and 2021-22), the NCV QBP Clinical Handbooks (AA & LEOD) have been updated to include outpatient procedures, but outpatient procedures have not yet been formally added to the QBP Definition. The purpose of Phase 1 is to provide immediate flexibility to hospitals to use inpatient NCV QBP funding for outpatient procedures. To support this change, there will be no recovery of funds for inpatient QBP volumes not completed in FYs 2020-21 and 2021-22.
- In Phase 2 (starting in FY 2022-23), the ministry will perform a formal carve-out and pricing update to add outpatient procedures to the NCV QBP (including updates to the QBP Definitions used for funding).

5. Who in my organization should be aware of this policy change?

Hospitals are encouraged to share this information with their decision support, finance, vascular and interventional radiology program staff and other interdisciplinary staff at their hospital who contribute to the reporting of vascular procedures and care of vascular patients.

Reporting Requirements

6. What is the current data gap?

Prior to FY 2020-21, reporting of same day vascular volumes was only mandatory if done in fully equipped operating rooms, hybrid operating rooms and catheterization labs. Same day (outpatient) vascular activity performed in the IR suite was not mandated for reporting in NACRS, which created a significant data gap.

Based on the recent Vascular IR Current State Survey conducted by CorHealth from September-November 2020, the following was noted about the current data gap:

- The majority of the 20 hospitals with a vascular program in Ontario perform same day LEOD procedures in the IR suite;
- It is estimated that 40%- 45% (1,400-1,600) of total same day LEOD procedures performed annually in Ontario were not captured in Canadian Institute for Health Information (CIHI);
- Annual same day IR suite LEOD volumes across hospitals ranged from 0 to 244 procedures;
- Most programs were successfully able to identify their same day IR suite volumes and submit clinical and patient characteristics for a retrospective 90-day period within two months; and
- Some hospitals were already coding same day (outpatient) vascular procedures performed in the IR suite into NACRS on a voluntary basis.

7. What are the data collection and reporting requirements of this initiative/policy change?

Per the memo from the ministry on February 26, 2021 to Ontario Hospitals and OH Regional Leads re: "Expansion of Non-Cardiac Vascular QBP to Include Outpatient Procedures", to ensure that there are no gaps in data, hospitals are now required to code all AA and LEOD same day (outpatient) procedures performed in the IR suite into NACRS.

Mandatory reporting has now been implemented with retroactive reporting to April 1, 2020 (with a reporting deadline of May 31, 2021 for FY 2020-21).

To support hospitals with this activity, CorHealth hosted an information and knowledge sharing session for hospitals on March 19, 2021.

8. Is there a recommended Management Information System (MIS) Functional Centre under which same day (outpatient) vascular procedures performed in the IR suite should be coded?

Currently, hospitals report outpatient vascular procedures under the following MIS Functional Centres:

MIS Functional Centre	Description
71260*	Operating Room (OR)
71360*	Day Surgery OR
71362*	Day Surgery Combined OR & Post-Anesthetic Recovery Room (PARR)
71365*	Day Surgery PARR
7141555*	Catheterization Lab
714152400*	Interventional Radiology

The first five Functional Centres listed above are currently mandated in NACRS.

In general, hospitals should report outpatient vascular procedures in the location where they occur. Based on results from the Vascular IR Current State Survey conducted by CorHealth from September-November 2020 and in consultation with CIHI, CorHealth is recommending that outpatient vascular procedures done in the IR suite that are now mandated for coding be reported under the Interventional Radiology Functional Centre (714152400). When outpatient vascular procedures

are formally added to the NCV QBP Definition in FY 2022-23, all qualifying Functional Centres will be listed.

In addition, the ministry will release an updated NACRS Mandatory Functional Centre document in the near future where the IR Suite Functional Centre will be listed as part of the reporting Functional Centres, effective FY 2020-21.

9. When will the QBP Volume Tool be updated to include NACRS LEOD or AA volumes as outlined in the updated NCV QBP Clinical Handbooks?

When the FY 2022-23 QBP Definitions have been updated to include outpatient procedures for the NCV QBP, these procedures (actual cases completed) will also be reflected in the QBP Volume Tool. Therefore, the FY 2022-23 QBP Volume Tool will include outpatient procedures for the NCV QBP.

In the meantime, the FYs 2020-21 and 2021-22 QBP Volume Tools will continue to report actual cases completed for the NCV QBP based on the current Definition in the FYs 2020-21 and 2021-22 QBP Definitions (which include inpatient procedures only).

The QBP Volume Tool is available on the Health Data Branch Web Portal on the "Quality-Based Procedures" page at:
https://hsim.health.gov.on.ca/hdbportal/HSFR_Quality_Based_Procedures
(user registration required)

10. When we code our AA and LEOD procedures performed in IR suites into NACRS, should we include only elective procedures (per the current QBP Definition) or all procedures (including urgent/emergent procedures)?

As there is no existing mechanism in NACRS to separate elective from urgent/emergent procedures, hospitals are required to report both elective and urgent/emergent procedures together in NACRS in FY 2020-21. Opportunities to separately identify elective cases and urgent/emergent cases in NACRS are being investigated for implementation in FY 2021-22.

11. Are hospitals expected to implement the anticipated coding changes for AA and LEOD procedures in FYs 2020-21 and 2021-22?

The May 7th, 2021 communication from CorHealth re: "Vascular QBP Expansion Initiative – Anticipated code changes in FY 2022/23" was intended to provide hospitals with advanced notice regarding anticipated updates to the NCV QBP Definitions for FY 2022-23 and an opportunity to align coding practices in FY 2020-21 and FY 2021-22 with these anticipated changes.

Per the May 7th communication:

- The codes to be included in the QBP Definition in FY 2022-23 are not currently funded through the QBP in FYs 2020-21 and 2021-22; and
- The codes that will be excluded from the QBP Definition in FY 2022-23 will continue to be funded through the QBP in FYs 2020-21 and 2021-22 until the formal update occurs in FY 2022-23.

For FYs 2020-21 and 2021-22, hospitals should code procedures that reflect the current QBP Definition AND those that will qualify under the anticipated updated QBP Definition in FY 2022-23. This will ensure that the carve out in FY 2022-23 to formally add outpatient AA and LEOD procedures to the QBP Definition will include all relevant procedures.

Additionally, hospitals should not yet discontinue reporting those codes that are anticipated for exclusion from the QBP Definition in FY 2022-23 so as not to lose the opportunity to continue to have those procedures qualify for QBP funding in FYs 2020-21 and 2021-22.

12. Do repair procedures to correct a complication of an index procedure qualify for NCV QBP funding?

To qualify for NCV QBP funding, procedures must satisfy the inclusion criteria, CCI codes and MRDx codes described in the QBP Definitions for Local Health Integrated Network (LHIN)-Managed QBPs. The FY 2020-21 version will be released in June 2021; in the meantime, hospitals can refer to the 2019-20 QBP Definitions for LHIN-Managed QBPs (version 6), as the NCV QBP definition did not change in FY 2020-21

(with one small exception to add Halton Healthcare Services to the list of hospitals approved to use NCV AA QBP funding for endovascular aneurysm repair (EVAR) procedures).

The QBP Definitions for LHIN-Managed QBPs is available on the Health Data Branch Web Portal under "Clinical Handbooks & Definitions" at:
https://hsim.health.gov.on.ca/hdbportal/HSFR_Quality_Based_Procedures
(user registration required)

Generally, procedures that are done to repair a complication of a previous procedure, rather than as an index procedure, do not qualify for funding under the NCV QBP. Using endoleak embolization as an example (to repair a complication of a previously implanted stent for an aortic aneurysm), it is assumed that the MRDx code for this case would not be one of those listed in the QBP Definitions (i.e., I712, I714 or I719); rather, the MRDx would be classified to a T-code which indicates the post-intervention condition, and as such, would not qualify for funding under the NCV QBP.

Funding Considerations

13. Are there implications to changing funding policies for the NCV QBP without a corresponding change in funding or volumes?

The current AA and LEOD QBP subgroups exclude same day (outpatient) procedures. Volumes for this patient population are funded through hospital global budgets. In Phase 1 of the Vascular QBP Expansion Initiative, shifts from inpatient to outpatient procedures will be facilitated by allowing funding for inpatient QBP volumes to be used for outpatient activity.

To support this change, there will be no recovery of funds for inpatient QBP volumes not completed during the first two years of implementation (i.e., FYs 2020-21 and 2021-22). This is an interim approach to provide immediate flexibility to hospitals to use inpatient QBP funding for outpatient activity. In FY 2022-23, there will be a formal carve-out and price set for outpatient procedures and an update to the QBP Definitions for OH Region-Managed QBPs (i.e., definitions used for funding).

Since outpatient procedures have a lower cost than inpatient procedures, hospitals can use inpatient QBP funding to perform additional procedures on an outpatient basis.

For additional clarity:

- In Phase 1 (FYs 2020-21 and 2021-22), actual cases completed for NCV QBPs will continue to be based on the current QBP Definition, which is based on inpatient procedures.
- If a hospital under-performs its inpatient QBP volumes, there will be no recovery of funds for inpatient QBP volumes not completed (to provide immediate flexibility to hospitals to use inpatient QBP funding for outpatient activity).
- Since there will be no recovery for inpatient QBP volumes, the difference in the Case Mix Index (CMI) between inpatient and outpatient procedures will not factor into volume reconciliations in Phase 1 (FYs 2020-21 and 2021-22).

- If a hospital over-performs its inpatient QBP volumes, the ministry will continue to net over-performance in NCV QBPs against under-performance in other QBPs (both elective and non-elective).

14. Are hospitals able to reallocate funding from other QBPs to cover outpatient AA and LEOD procedures until the formal carve-out in FY 2022-23?

The purpose of Phase 1 (FY 2020-21 and 2021-22) is to provide immediate flexibility to hospitals to use inpatient NCV QBP funding for outpatient procedures.

Per the QBP Volume Management Instructions (VMI) and Operational Policies, which are distributed to OH Regions and hospitals annually, OH Regions can also reallocate volumes and funding from under-performing QBPs (both elective and non-elective) to over-performing elective QBPs, including the NCV QBP, within and between hospitals.

Hospitals are asked to consult with their OH Region regarding QBP reallocations.

15. When we take outpatient AA and LEOD procedures into account, our hospital over-performs our inpatient NCV QBP volumes. Will the ministry provide additional funding for outpatient AA and LEOD procedures?

The purpose of Phase 1 (FY 2020-21 and 2021-22) is to provide immediate flexibility to hospitals to use inpatient NCV QBP funding for outpatient procedures.

Prior to FY 2020-21, outpatient AA and LEOD procedures (including those performed in IR suites) were funded exclusively through hospital global budgets.

With the policy changes announced on February 26, 2021, hospitals now have three potential streams of funding for outpatient AA and LEOD procedures for FY 2020-21 and FY 2021-22:

1) Hospital global budgets (status quo)
2) Inpatient QBP funding (new – increased flexibility to use existing allocated NCV QBP inpatient volumes to fund outpatient procedures)
3) Additional inpatient QBP funding through OH Region reallocations (new – ability to work with OH Regions to perform reallocations to fund additional

inpatient NCV QBP volumes, which can be used to fund outpatient procedures)

At this time, the ministry is not planning to provide additional funding for outpatient AA and LEOD procedures over and above these three streams of funding (one existing and two new).

16. When we take outpatient AA and LEOD procedures into account, our hospital over-performs our inpatient NCV QBP volumes. Can we net over-performance from outpatient AA and LEOD procedures against under-performance in other QBPs?

For Phase 1 (FY 2020-21 and FY 2021-22), there is no netting of over-performance in outpatient AA and LEOD procedures against under-performance in other QBPs because the NCV QBP has not yet been formally updated to include outpatient procedures (this will not happen until Phase 2 of the expansion).

In Phase 2 (starting in FY 2022-23), the ministry will perform a formal carve-out and pricing update to add outpatient procedures to the NCV QBP (including updates to the QBP Definitions used for funding). At that time, the standard QBP volume management policies will apply to both inpatient and outpatient procedures, i.e. starting in FY 2022-23, over-performance of inpatient and outpatient NCV QBP volumes will be netted against under-performance in other QBPs (both elective and non-elective).

17. If FY 2020-21 data will be used for the carve-out, how will the impact of COVID-19 be considered?

The impact of COVID-19 on FY 2020-21 volumes will be assessed for fit-for-use in the vascular QBP carve-out of outpatient activity. Based on the assessment results, mitigation strategies/alternative approaches will be considered and implemented. If it is identified that FY 2020-21 data are not representative, the ministry will use FY 2019-20 data (both clinical and costing), potentially including the estimated volumes which were completed in IR suites but not captured via NACRS (i.e., from the Vascular IR Current State Survey conducted by CorHealth).

18. Will there be any financial compensation for hospitals to support the coding requirements related to this policy change?

The ministry does not provide financial compensation to support coding requirements related to QBPs. However, during Phase 1 of this initiative, hospitals can use inpatient funding for outpatient procedures. This may provide a “financial buffer” as a result of the relatively lower cost of outpatient procedures compared to inpatient procedures. This “financial buffer” may be used to support the increased cost of additional coding requirements, as an example.

19. Once the carve-out happens in FY 2022-23, will inpatient and outpatient funding be blended or in separate funding lines?

The approach to establish a price for outpatient NCV QBP procedures in FY 2022-23 will be based on an analysis of activity and costing data. In general, the aim of the pricing approach is to reflect resource requirements in alignment with the provision of best-practice care; expanding the vascular QBPs to include outpatient procedures will remove any financial barriers that may impact shifting from inpatient to outpatient procedures, where appropriate for patients.

20. Hospitals in high-volume growth areas have already increased outpatient AA and LEOD volumes without a matching growth in global funding. If the carve-out is based on FY 2020-21 volumes, is there a risk of carving-out unfunded dollars?

The QBP funding methodology implements a carve-out from hospital global budgets, followed by a QBP funding allocation based on clinical and financial data reported by hospitals. This is the standard approach for all QBPs (it is not unique to the NCV QBP). The ministry will continue to work with OH Regions to monitor the financial position of hospitals.

21. For FY 2020-21, can QBP funding be used retrospectively for outpatient AA and LEOD procedures?

Yes, with this update, hospitals were able to use inpatient NCV QBP funding for outpatient AA and LEOD procedures in FY 2020-21 (i.e., retroactive to April 1, 2020).

22. Does the NCV QBP only include OHIP procedures?

Per the QBP Definitions (Section 5.0 Universal QBP Exclusions and Notes), only Ontario Health Insurance Plan (OHIP) patients qualify for QBP funding.

This document is available on the Health Data Branch Web Portal under "Clinical Handbooks & Definitions" at:
https://hsim.health.gov.on.ca/hdbportal/HSFR_Quality_Based_Procedures
(user registration required)

General Enquiries

23. Who can I contact if I have questions?

For clinical questions, please contact the CorHealth Ontario Service Desk at service@corhealthontario.ca.

For questions related to QBP funding, please contact the Ministry of Health at HSF@ontario.ca.

Questions related to NACRS data submission and coding can be submitted via CIHI's eQuery tool under My Services and by selecting Inpatient/ambulatory abstracting and education (DAD & NACRS) as the question topic.