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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: August 12, 2011

TO: All Medicare Advantage Organizations

FROM: Danielle R. Moon, J.D., M.P.A
Director

SUBJECT: Issuance of Update to Chapter 5 of the Medicare Managed Care Manual

Included with this memorandum is an updated version of Chapter 5 of the Medicare Managed Care Manual, "Quality Improvement Program." The chapter, which is part of the Publication 100-16, may be accessed online at http://www.cms.hhs.gov/Manuals/IOM. This chapter provides Medicare Advantage (MA) organizations with detailed, updated information to use in implementing and maintaining a quality improvement (QI) program. The draft update was issued for public comment on March 11, 2011. We received approximately 111 unique comments from 26 organizations and considered those comments carefully as we finalized Chapter 5.

We received a significant number of comments and recommendations related to our requirements for Chronic Care Improvement Programs (CCIPs) and Quality Improvement Projects (QIPs) in sections 20.3 and 20.4, respectively. We made few changes to these sections because the information regarding CCIPs and QIPs articulated in this version of Chapter 5 reflects current requirements for CCIPs and QIPs. As we stated in the contract year (CY) 2012 Call Letter, we do not anticipate that the next CCIP and QIP collection will occur until CY 2012. We are currently in the process of revising the CCIP and QIP reporting tools and will be issuing new guidance later this year on changes to the CCIP and QIP templates, scoring methodology, benchmarks, and any CMS identified CCIP and/or QIP topics. We will provide sufficient lead time for plans to implement the new guidance and to modify their operations, and will also provide training and technical assistance calls to plans prior to submission. We appreciate the feedback we received from external stakeholders and will take those comments, as well as the comments we receive through the Paperwork Reduction Act (PRA) process for the new CCIP and QIP tools, into account in updating this guidance. These changes will be reflected in the next update of the chapter, which we intend to issue in the spring of 2012.

We also received a few requests for clarification in section 70 - Quality Improvement Organizations (QIOs), which describes the role of QIOs in monitoring and assessing MA organization quality improvement (QI). We did not make any changes to this section, since it describes our current regulatory authority to acquire data from QIOs for QI and monitoring under the MA program. While the QIOs are currently primarily focused on quality in the Medicare fee-for-service program, we are working toward collaboration on MA QI initiatives in the future.

Finally, we received several comments in response to section 90 (Standard MAO Reporting Requirements for HEDIS®, HOS, and CAHPS®). The comments primarily focused on issues related to plan ratings, a topic which is not addressed in this chapter. We do, however, appreciate the comments and will give them full consideration as we continue to develop plan ratings for future years.

In addition to revised and updated definitions of terms used throughout the chapter, and minor clarifications or grammatical changes, other differences between the draft and final versions of the chapter include:

- **Deletion of Section 20.2 (Administration of the QI Program).** In previous versions and the draft manual chapter, section 20.2 included a list of administrative and management arrangements required under our contract with MAOs. In response to a comment we received opining that these requirements were already included in Chapter 11 of the Medicare Managed Care Manual ("Medicare Advantage Application Procedures and Contract Requirements"), we deleted section 20.2. As a result, the remaining section 20 subsections have been renumbered.

- **Revisions to Section 60.3 (QI Program Requirements for Special Needs Plans).** We updated the section to include the following subsection that provides additional general guidance related to quality reporting requirements**:**

    - **Section 60.3.2.4 (Medicare and Medicaid Quality Reporting Requirements for D-SNPs)**

We thank the various stakeholders who submitted their comments and feedback for consideration. We believe these efforts have helped us improve the clarity and comprehensiveness of Chapter 5. If you have any questions about the policies articulated in Chapter 5, please contact your Regional Office account manager.