

## **CY 2016 QIP Plan Section Training – October 5, 2016 Closed Captioning Transcript**

Hi, good morning and good afternoon, depending on where you are. My name is Donna Williamson. I'm with the Medicare Drug and Health Plan Contract Administration Group. And I'm here today with the Quality Team. Joining me, I have Susan Radke, Brandy Alston, Theresa Wachter, Betsy Ricksecker, and Tracey Herring. And we want to thank you all for joining us today and welcome you to the Contract Year (CY) 2016 QIP and CCIP Plan Section Training.

Today's presentation will include a background on QIPs and CCIPs. We will also talk about Reducing All-Cause Hospital Readmissions, and what we are doing is providing you with lessons learned and the results from that first full three-year completed QIP cycle. We will talk about the mandatory QIP topic along with the CMS quality strategy goals, and touch more upon the expectations surrounding promoting effective management of chronic disease. We will also talk about changes to HPMS, Plan Section requirements, potential outcome measures, and give you some examples as well as CCIP Plan Section requirements and the MMP submission requirements of the Medicare and Medicaid plans.

So before we do that I would like to discuss some of the important dates, these are upcoming activities as well as to let you know that today's slide presentation is available on the MA quality webpage. And also, the templates for the QIP Plan Section submission. In addition to today's training session, for the QIP Plan Section, as well as the CCIP Plan Section requirement, we are also going to be providing a follow-up question and answer session to this, and that will be on October 26, 2016, from 2 to 3PM Eastern Standard Time (EST). We changed some of the resource material for the industry and we will provide more detail on that, but you'll see this reference here to a QIP and CCIP resource guide, and again we will provide more detail, but what we've done this year is separate out the technical HPMS guidance from the actual Plan Section requirement. So the resource document we hope to get up on the MA quality webpage, next week sometime, and that will be the week of October 10. The HPMS QIP User Guide will be released and available in HPMS on October 28. And the QIP Plan Section submission window, the gates open on October 31 at 12AM and the gates close at 8PM on November 4, 2016. The QIP Plan submission window will be the week of October 31, beginning at 12 midnight and closes on November 4 at 8PM. I also want to let you know that for plans that fail to submit during this submission window, they will receive a notice of non-compliance (or a NONC) for failure to submit. New QIPs that are submitted for CY 2016 will be implemented in January 2017, and the Annual Update submission window will be in January 2017. And we will be giving you more information about the Annual Update submission, but this training session is just going to focus on the QIP Plan Section.

To provide you with background on the QIPs and CCIPs, the CMS regulations at 42 CFR 422.152 outline the quality improvement or QIP requirements for Medicare Advantage plans. The two key requirements are the development and implementation of a quality improvement project or a QIP and the development and implementation of a chronic care improvement program or CCIP. The regulations also specify that plans will record their progress to CMS and both QIPs and CCIPs focus on interventions and outcomes and utilize the Plan, Do, Study, Act, or the PDSA model for quality improvement.

Therefore, before we move on to the Plan Section requirements, I would like to provide you with some information on the last mandatory topic and that was Reducing All-Cause Hospital Readmissions. CMS had implemented or mandated this topic in 2012. For all plans that submitted a QIP in 2012, those QIPs became operational in 2013, and they completed their third project year because all QIPs have a three-year project cycle. They submitted those Plans, submitted their final results for a full three years in the Fall of 2015. To evaluate those QIP initiatives, we awarded a contractor to conduct an analysis of the first, again the full three-year cycle. The contractor was tasked with developing a comprehensive analysis of the QIP report. In summary, they developed an understanding of information contained in the QIP report, they assessed the level at which QIPs are successful at reducing hospital readmissions, they also took a deep look into the most common barriers and mitigation strategies, and they also identified key lessons learned and best practices. We also asked them to make recommendations to improve future data collection, so for example, they have given us some really good recommendations for the 2016 QIP submissions, and they also gave us recommendations to streamline data capture, so that we can improve our analysis and summarization of the outcomes and the results. As we've said before in the past, we are always looking to show attribution of your efforts and share with the industry best practices so that we can improve the program and also support the quality strategy goals.

Due to the structure of the data, meaning the requirements that we implemented and that you all followed to submit those initial QIP Plan Sections, so again, back in 2012, we ended up collecting a lot of data and a lot of that data was very unstructured or a lot of narrative or qualitative text. We were looking for that and we saw lots of narratives, so we wanted to really see what you all were doing and what your best practices were and what types of interventions you are doing and give us detail, and that was great. But our challenge then became trying to look through all of the data and really capture what's valuable and looking to see how we have reduced or how you all through your QIPs have reduced the all-cause hospital readmission rate. The contractor faced a lot of challenges in exploring the data, trying to validate their results. But despite those challenges, I'm very happy to say that the contractor developed and implemented a process to extract structured information so it could be organized into an analytical data set. Once they developed a workable data set, they summarized the data and were able to gain insight into these QIPs. In summary or just at a high level, they parsed the data out, providing us with many different aspects they gave us a very comprehensive report. But I thought for purposes of this discussion and this training, I wanted to let you know that 71% of the QIPs reported a reduction in their all-cause hospital readmission rates, so that's good news. And 41% of the QIPs submitted reported meeting their goals. For those of you who weren't familiar, QIP Plan Sections have to have a quantifiable and a measurable goal, and we are always looking to see what specifically are you looking to do, what interventions are you employing to do that, and what were your results? And did you meet your goal?

This is the changes in readmission rates. This breaks out in specific percentages what areas of reductions in these rates did we see. For example, we had over 38% reported a decrease in their readmission rates between a 1 to 5% decrease. I won't go through all of these because I think these are pretty self-explanatory. We were pleased to see that the numbers did move and we learned a lot. I think you all learned a lot from these initiatives as well.

Some of the common barriers that our contractor identified through their analysis were, a lot of healthcare team issues. Whether that was at the provider level, or within the plan level, they saw a lot of communication issues, non-compliance issues, some from the enrollees and then also linking back to the provider. We saw a lot of problems with the partnership that plans have to develop with their providers to be successful. We also saw a lot of plans citing technology issues, external influences, problems around medications, whether that's enrollees not understanding medications or the ability to get medications filled. The duplicative medications, problems with support systems, transportation as well as financial and the social support issues. Some of the mitigation strategies that were documented include working with healthcare team at the provider level but as well as internally with the plan level to facilitate and enable better communication, coordination, looking at which enrollees really need case management. Also, we saw a lot of plans referencing various IT solutions and getting better systems or using their technology smarter. We saw a lot of plans referencing post-hospital discharge care, the follow-up appointment coordination and working with beneficiaries to make sure they understand the discharge instructions.

Some of the best practices and lessons learned include enhancing communication among all healthcare team stakeholders as well as provider engagement, but also caregiver engagement and connecting with their enrollees and how vital that was. Some MAOs found that their best investment was in analytical infrastructure, so again going back to the technology and IT solutions to help identify and target enrollees, especially those who are more vulnerable, that are sicker, more frail, and have multiple chronic conditions so that they can better address their issues and be much more proactive in managing those patients and helping them to manage their conditions. Plans also cited evidence-based tools to help MAOs as well as providers better understand and address risk factors. They also cited case management, disease management programs, better training at the MAO staff level and also a focus on weekend discharges so that they saw patients that were admitted and discharged over the weekend often fell through the cracks. By the time they identified those enrollees, so much time had elapsed that the interventions weren't really effective, so they started to really work with the providers as well as the internal plan staff to make sure that they are capturing and managing those patients that are discharged on the weekends.

Some of the best practices and lessons learned that were cited, the primary care or the PCP involvement, making sure that the PCP is involved earlier in the care and making sure that enrollees get to those providers in a timely manner and ensuring that they are getting more of the preventive care and appropriate treatment. Improving education, of the case managers, the primary care physicians and the caregivers, and some plans also referenced end-of-life care and decision-making. Helping enrollees and their caregivers navigate through sometimes difficult situations. Plans also, through QIP development or while they were developing this QIP internally, some of the things they referenced for themselves as a lessons learned or best practices, to make sure that in the QIP development, set goals that are measurable, identify metrics, making sure you are optimizing or analyzing your data and implementing interventions accordingly. That's linking back to setting your goals internally but also utilizing their data. Now I will turn this over to Susan Radke who will talk about the CMS 2016 quality strategy goals.

Thanks, Donna. As you know CMS is committed to improving the quality of care for all beneficiaries. In selecting the new QIP topic, we felt strongly that it should align with the CMS quality strategy goals that are listed on this slide. We encourage you to visit the CMS website for more in-depth information on our quality strategy goals. Our current topic focuses on the goal that is listed in the bullet point four. Which is promoting effective prevention and treatment of chronic disease. As already announced, CMS has chosen the promote effective management of chronic disease as a mandatory topic. We believe that many of the interventions and activities you will be doing in your QIPs will help to support several other of the quality strategy goals, as many of these goals overlap or build upon one another. Overall, we believe the interventions associated with this topic have the potential to improve health outcomes for enrollees with chronic conditions, as well as advance CMS's effort to ensure beneficiaries receive appropriate, effective, high-quality, and effective care coordination. Per the regulation, QIPs should have favorable effects on health outcomes and enrollee satisfaction. In addition, plans should target their populations in a manner that will help to address and eliminate gaps or disparities in care. This would be by effectively managing chronic conditions. It is expected to slow the disease progression. The focus is to help to prevent complications and development of comorbidities. It helps to prevent emergency room encounters and inpatient stays, improves the quality of life for the enrollees, and provides cost savings to the plan and the enrollees.

CMS believes that MAOs and SNPs are in a unique position to play an important role in promoting effective management of chronic disease. By care coordination and care management, providing appropriate services including prevention, by collaborating and having partnerships among stakeholders, enrollees, caregivers, etc. And they have the ability to link to appropriate resources. We specifically see MAOs and SNPs being very instrumental in promoting these various activities. The role of the MAO/SNP is to promote the use of provider tools to better manage chronic conditions, provide caregiver engagement and enrollee engagement, participate in disease management programs, to improve self-management skills and health literacy, provide health information exchanges across provider settings and addressing gaps and disparities in care. Please note that this list isn't all-inclusive. These are just some ideas to take under consideration as you begin developing your interventions. We believe these could potentially be promising approaches that support the QIP objectives and improve care for MA enrollees with chronic conditions. Next, Brandy will be talking about your QIP Plan Section submissions.

Good afternoon, everyone. I will be providing some information about your 2016 QIP submission requirements. First, please be reminded that each MAO must establish a single QIP for all non-SNP coordinated care plans and network-based MSA/PFFS plans offered under a single contract. Cost plans and PACE plans are excluded. Also, please be reminded that starting in 2016, MAOs will no longer be required to submit a QIP for each individual SNP PBP. We have consolidated SNP submissions so that MAOs by contract will submit a single QIP per SNP type/subtype. All affected contracts have been notified of their 2016 SNP submission requirements. If you have SNP contracts that have not received a consolidation letter, or have questions about your 2016 SNP submission, please contact us via our Medicare Part C Policy Mailbox, which will be linked at the end of this presentation. We are happy to provide additional clarity. Also, who will be submitting Plan Sections this Fall? Plans completing their

third year of their QIP cycle will submit a new QIP Plan Section this Fall. Also, MAOs with new contracts or new SNP subtypes first effective in January 2016 will also submit a new Plan Section this Fall.

We have made some minor changes to the QIP Plan Section data entry navigation and design. Which includes more logical flow and overall navigation and more standardized responses, such as the use of drop-downs and radio buttons. We believe these small changes will improve the intuitiveness and overall usability of the QIP module. For assistance on how to navigate plan user data entry, please refer to the HPMS QIP User Guide, which will be available October 28 in HPMS. If you encounter any HPMS problems, we ask that you contact the HPMS Help Desk. For assistance with HPMS access, we ask that you email [HPMS\\_access@cms.hhs.gov](mailto:HPMS_access@cms.hhs.gov).

Second, there are changes to our guidance documents this year. The HPMS User Guide will be technical only. You will use this for HPMS navigational purposes only. CMS will provide a separate Resource Document with specific instructions regarding the content of your submissions. The document will provide more detailed guidance regarding CMS expectations. This document will be called the QIP/CCIP Resource Document. CMS will post this on the Quality website. We anticipate having this available the week of October 10. Please remember, the HPMS User Guide will be technical only.

Now we will discuss the various sections of the QIP Plan Section. Section A, the top of the data screen as you can see in the screenshot here, will display MAO information that was already entered in HPMS for a particular plan. Note that if the information on the MAO's quality contact or compliance contact is incorrect, the MAO must edit the contact information using the set-up plan function in HPMS. Instructions on how to update contact information is contained in the Bid Submission User Manual. Also, please note the data entry page in the screenshot. You will be inputting data by section. Now we will go over each data entry section.

Section B includes QIP summary information. B-1, title of your QIP. Here you will provide the title of your QIP. Please be sure to include the target chronic condition in your title. The character limit is 150 characters. B-2, the implementation date, will be the same for all new QIPs, January 2017. B-3, target diagnosis. Here you select a chronic condition. B-4, description of QIP. In this section, please provide a brief summarized description of the QIP and include the following information: target chronic condition and overall anticipated outcomes, rationale for selection, target population, planned interventions, the target goal and how progress will be measured, including data sources. The character limit for this section is 1500 characters. B-5, clinical guidelines used to shape QIP. In this section, please provide clinical guidelines/standards of practice that will be used to guide or shape the QIP, as well as serve as the basis for your target goal, interventions, education, and other aspects.

This is Donna Williamson, I just want to add to that, please don't leave that field blank. All QIPs must have a reference to a clinical guideline or standards. Last year we did see quite a number of submissions that have that field blank and that is not acceptable. If we do see that, we will be asking you to resubmit. Thanks.

And also, an example of clinical guidelines, the American Psychiatric Association and National Institutes of Health, National Kidney Foundation, American Diabetes Association, American College of Cardiology, National Heart, Lung, and Blood Health Resources Service Administration. These organizations provide clinical guidelines that can be drawn upon.

This is attachment A, from the HPMS memo announcing the mandatory topic for QIPs that was issued last year. This lists the chronic conditions on the list from which you can select. Those marked with an asterisk can only be selected if it is not currently a part of a current CCIP initiative.

Section C includes enrollee population information. C-1, total enrollment. In this section, you will provide the total number of enrollees at the time of submission. This is a numeric field. C-2, population description. In this section, you will provide (1) the clinical and/or demographic makeup of the MA population, the opportunity for improvement, and how the implementation of the QIP will improve health outcomes for the target population. And (2) the estimated number of enrollees with the selected chronic condition that meet the inclusion criteria for the QIP initiative. This section has a character limit of 1500 characters. An example of a population description, for example, 30% of our populations are diabetic, 10% have chronic kidney disease, 40% of our enrollees have behavioral health conditions. In terms of demographic makeup, information such as race, ethnicity, language, income, etc. will help to identify potential areas of need as well as provide a true reflection of the population you are serving. For example, based on your description of your population, you may identify a significant portion of your population may benefit from certain community resources, language-appropriate materials, help paying for prescriptions, etc. For example, you may say that X number of enrollees with chronic obstructive pulmonary disease, COPD, must meet the QIP target population inclusion criteria. The character limit, again, for this section is 1500 characters.

Moving onto section D. Section D includes information concerning the goal of your QIP. This section, D-1, is divided into two parts. First, you will identify a quantifiable goal. Here you will enter a number or percentage. In submissions last year, we found it at times difficult to find what the quantifiable goal was. We had to search the submission at various places, so we divided the section. The first part of D-1, you will identify that quantifiable goal. For instance, you may say something in the section along the lines of increasing antidepressant medication adherence by X percentage. We want to be able to see it clearly. The second part is a description of the goal. The second part you will describe the goals, a written description, any additional information that you want to provide regarding your goal. For instance, you may say increasing the percentage of enrollees in the target population who remain on a depression medication for at least a certain amount of days by a certain known percentage by a certain year. So it's a little bit more detailed from the first box. Next Donna has some additional information about things to consider with your target goal.

Thanks, Brandy. On this particular slide, these are really example goals but from a high level. So as Brandy was describing in that prior submissions, plans seemed to struggle with articulating a specific and a quantifiable goal. So these particular examples are at a high level. I'll be providing these, but in addition to providing this, we also want you to provide a specific percentage so that you have something to work towards. And this is, again, providing a

measurable outcome. For example, some of the potential target goals that plans provided in previous submissions, reducing unplanned inpatient hospital admissions, so we would look to see by 10%. Or reducing emergency or ED visits for example COPD by 10%. So then in the description field, they could describe to us that last year we had 20% of our CHF patients were hospitalized, we'd like to work to decrease that by 50%. Some other examples, improving or increasing follow-up visits after discharge or an acute event, or more specifically making sure that those enrollees see their primary care provider, mental health, or other appropriate provider visits. I also want to point out as well that if you are looking to improve recommended preventive care utilization, that just has to be one aspect of your QIP. For example, we saw some submissions last year that promoted various screening tools, for cancer, or for depression. However, you need to make sure that you are also incorporating actual or active management for those conditions. For example, if you are promoting the use of the depression screening tool, you are also taking that a step further to make sure that those enrollees are then appropriately managed. Making sure they are following up with a mental health provider, that they are getting medication as needed, or other types of treatment. We ask that you not submit a QIP that focuses on prevention. It also must include the management of a condition. Other examples, ensuring appropriate therapies or medications as prescribed, so for example, anemia management and ESRD, persistent medication for diabetics, or last year we saw some really great submissions for diabetes that looked at making sure those enrollees are getting appropriate medication. Education, lifestyle changes, and in particular, the target goal for those QIP submissions was improving the A1C level. Also improving therapeutic monitoring, for example Coumadin or other pharmacological agents.

Some other examples for target goals: medication reconciliation, improving medication adherence, especially for the mental health conditions. Increasing the number of enrollees actively participating in disease management programs, or increasing the number of enrollees receiving community support services. And increasing engagement of enrollees and their caregivers. Around education, symptom management, safety, and individual goal setting for those enrollees and their families, especially with more advanced chronic conditions. These are some examples and it's not meant to be all-inclusive list, but we did want to provide that so it can give you some frame of reference and see how these are appropriate. For your population or what goals are you deciding upon. As you can see, some of these are generic enough that they could be applied to many of the conditions, however it's important to select a measure that's appropriate for the target condition as well as the target population. If you have any questions or would like some additional suggestions and/or thoughts from CMS, please don't hesitate to contact the MA/Part C Policy Mailbox. And again, this is provided at the end of the presentation in the resource slide.

Thank you, Donna. Continuing with section D. D-2, baseline. Here, please provide a baseline that you have at the point of comparison as you measure your progress over your three-year cycle. This character limit will be 1500 characters. D-3, national standard, if applicable. Provide a national standard for the target goal if one is available. For example, medication adherence rates, percentage of hospitalization for COPD or other chronic conditions. Or you may also reference a best practice or a nationally recognized framework, for example, the Substance Abuse and Mental Health Services Administration (SAMHSA) has a national behavioral health quality framework that aligns with the national quality strategy and provides

key behavioral health indicators for quality care. This is a great resource that provides both current and future quality measures for evidence-based practices, person centered care, care coordination, and reducing adverse events for behavioral health outcomes. Another example of a national standard is the national standards for diabetes self-management and support from the American Diabetic Association. Standards include recommendations on program development, and coordination, curriculum, patient access, patient progress, and ongoing support. The character limit for this section is also 1500 characters. D-4, data sources used to measure the goal. In this section, please select all of the data sources that you will use to measure your goal. There is one other field in which you may choose something that may not be listed in the radio buttons that we will have listed. If you do select other, please describe what data you are using.

Next, section E includes information concerning your planned interventions. In this section, you identify and discuss your planned intervention or interventions. E-1, select planned intervention type or types. In E-1, you will select which type or types of intervention you plan to implement. You may select up to three.

E2-A, description of intervention. In this section, you will describe the planned intervention in a clear and logical way. Be sure to show how the intervention will help to achieve the target goal and improve health outcomes. E3-A, measurement methodology. Measurement methodology is the means, technique, procedure, or method used to collect data and measure the effect of an intervention. Please provide the methodology you will use to collect data and measure the success of the intervention or interventions. For example, you may say, we will utilize claims data to measure the number of enrollees with cancer that are experiencing unplanned admissions and/or ED visits. We're looking at the number of enrollees that received evidence-based recommended services as a part of effectively managing their condition. Another example could be that we are analyzing Part D data to measure medication adherence. You will repeat up to three as needed, depending on the number of interventions you select. Again, you can select up to three interventions.

Once you have submitted your QIP Plan Section, CMS will begin the review process. To help facilitate documentation and communication, we have enhanced our review module so that the reviewer may enter comments about your Plan Section, at the conclusion of the review. If the reviewer determines that resubmission is required, the comments that have been entered in the module will be sent to you and a disapproval email from HPMS. Additionally, if during the review process, a reviewer has specific questions, comments, or concerns about your Plan Section, you may be contacted directly by CMS. Finally, a general note about submission. When you submit your Plan Section, you will receive a confirmation number and a confirmation email from CMS. Please do not assume your submission has been successful if you do not receive a confirmation email from CMS. Anyone that does not successfully submit their Plan Section during the submission window will receive a notice of non-compliance. Moving on to our CCIP requirements.

This is Susan, again. This section, we will be talking about the chronic condition improvement program requirements. We will be talking about the CCIP mandatory topic. All of the CCIPs are required to focus on reducing the incidence and severity of cardiovascular disease over a five-year period. With the QIPs, you have projects that extend for three years, and with the

CCIPs your project will extend for five years. CCIPs must be clinically focused and support Million Hearts. Which is to identify people at risk for a heart attack or stroke, ensure they receive appropriate treatment, reduce the need for blood tests and cholesterol treatment, promote healthy diet and physical activity, and support smoking cessation to reduce current and future cardiac risk. As you see on our slide here, the CCIP should address some aspects of the ABCs of heart disease, which include A for the appropriate aspirin therapy, B for blood pressure control, C for cholesterol management, and S for smoking cessation.

MAOs are no longer required to report CCIP activities or progress to CMS via the HPMS module. However, you must comply with CCIP requirements per MA quality regulations. You must document and track your progress internally. We have simplified the CCIP requirements to mirror the QIP requirements. And although you are no longer going to report these in HPMS, you may document other aspects of your CCIPs internally.

CMS provides guidance to MAOs with developing, implementing, and tracking CCIPs in the CY 2016 QIP and CCIP Resource Document, which will be posted very soon on the CMS website. In developing the CCIP, MAOs must follow the Plan, Do, Study, Act (PDSA) model for quality improvement model. As you see here on this slide, all CCIPs must have a title, all CCIPs must have a target condition that includes the ABCs of cardiovascular disease, you need an implementation date, an overall description of your CCIP, clinical guidelines used to shape the CCIP, and a description of your population.

In identifying a quantifiable goal, an MAO will determine a baseline as a point of reference by which something can be measured, compared, or judged. In addition, the MAO should also identify a national standard or external benchmark. The MAO's baseline and/or national standard should be appropriate for measuring achievement of its identified goals. The MAO must also describe what interventions to be implemented and educational efforts used to meet specific goals of the target population, as well as what data sources it will use to measure the success of the project or program. As MAOs are evaluating how implementation of their CCIP initiative is going, plan staff are encouraged to discuss the progress as part of their ongoing routine communications with their CMS account manager. Again, this slide shows you what the requirements are for you to include in your internal documents on your CCIP.

This slide provides you with a list of resources. We encourage you to utilize these resources, and the CY 2016 Resource Document will be posted on the CMS MA quality improvement website very soon. Additionally, there are frequently asked questions posted on the Medicare Part C Policy Mailbox homepage, for your reference. On our resource list, we have our links to the MA quality improvement program website, links to the CMS quality strategy goals, our QIP HPMS User Guide, the HPMS Help Desk in case you have some technical issues with HPMS. This is the email or the phone number you need to call for technical issues. And in case you have any policy questions or questions regarding the content of your QIP, you can always contact and send an inquiry to the DPAP Mailbox. And with this, we will now switch over to the Medicare/Medicaid plans. And I introduce Betsy Ricksecker, who will discuss the QIP and CCIP initiative for the MMPs.

Thank you. Can everyone hear me? Good Afternoon. This is Betsy Ricksecker from the Medicare-Medicaid Coordination Office. I am going to be talking briefly about some things that are specific to MMP plans with respect to the QIP submissions and requirements. Under the financial alignment initiative, CMS is seeking to advance an integrated quality and performance improvement program through which all Medicare-Medicaid plans participating in the demonstration will submit a single set of quality and performance improvement projects that meet the requirements and needs of both CMS and the participating states, that avoid unnecessary duplication and reduce burden for plans.

To accomplish the goals of the integrated quality and performance improvement program, MMPs will submit all quality and performance improvement projects online through the HPMS module. For this year, that will be just the QIPs. We've had a change in policy and the CCIPs will no longer be submitted. The QIP module is located under the Quality and Performance tab. There will also be a joint review and approval process by CMS and the respective state. That's a little bit different from the MA plans that only have a single review process.

The quality improvement program requirements are located under CMS regulation 42 CFR 422.152. The requirements specify the submission of a quality improvement project - the conducting, and submission of a quality improvement project – and a chronic care improvement program, CCIP. As was previously indicated, we are no longer requiring the reporting of the progress related to the CCIP, however, MMPs must be conducting a CCIP and they must document and track their progress internally. For 2016, the information that will be submitted through the HPMS module will only be for the QIPs. I do want to point out that the CCIP requirements for MMPs are the same as what was just presented for the MA plans. For your reference, that information is located on slides 29-32 so that you can review those at your leisure. Those slides are available on the MA quality website. As was previously presented for the quality improvement program, the focus is on intervention and outcomes. And the utilization of the Plan, Do, Study, Act (PDSA) quality improvement model.

For CY 2016, MMPs will submit at least one improvement project via the HPMS module. That project will satisfy the general Medicare QIP requirements. The total number of projects an MMP must submit and the topics will be determined by each state, in consultation with CMS. The MMPs are not subject to the same mandatory topics as the MA-PD plans. And I want to mention that those topics were provided via HPMS memos to the respective MMPs that are participating in the state demonstrations. Those memos went out on September 23, 2016, so if you have not reviewed that information, I would suggest that you do so. You can also reach out to the MMCO quality mailbox, and I can provide copies of those memos if you haven't received them.

For the Plan Section submission that will be taking place, October 31 through November 4, the only MMPs that are required to submit their Plan Sections are those whose contracts were first effective at any point during calendar year 2016. That is specific to contract H9576 in Rhode Island, and contract H9869 in New York, participating in the FIDA-IDD demonstration. For the contract in Rhode Island, they have chosen to conduct and submit information on two QIP projects, and for the contract in New York, they have chosen to submit one QIP. And just as a

reminder, that submission window is from October 31 starting at midnight, through November 4 at 8 PM ET.

And for clarification, I want to emphasize that if there happen to be other MMP plans on the call, that MMPs that previously submitted a QIP Plan Section in either CY 2014 or CY 2015, you will be submitting an Annual Update as part of the broader QIP Annual Update submission that will take place in January 2017. And currently, the tentative time window for the gates to be open for the Annual Update submission are January 9, 2017, again at midnight, running through 8 PM ET on January 13. If those dates would happen to change, you would receive an HPMS memo providing you with that information. I also want to point out that there will also be an Annual Update training for plans and that will be scheduled in early December 2016. Information regarding that training session will also be sent to you via HPMS memo, as soon as all of those dates and times are finalized.

I'm not going to run through all of the submission windows again. We just had a wonderful presentation by Brandy that ran through a lot of those details. What I would like to emphasize is that there are very minor differences for the MMPs with their Plan Section submission. We have some additional data elements, and I will review just those and provide some further detail. Under part B, which is the summary of the QIP, MMPs have an option of selecting a nonclinical focus for their QIP topic. For MMPs, you can either have a nonclinical focus or a clinical focus and there is an additional data element to capture that. MMPs must also specify a domain for their QIP topic and must identify the impact for the plan members, identify anticipated outcomes, and provide a selection rationale.

This slide provides a screenshot and B-1 is the same, which is the QIP title. B2 is the additional focus data element, which is a radio button where you can select between clinical or nonclinical. Directly beneath that is the text box for the domain. If you select a non-clinical topic for your focus, then underneath the target diagnosis, we have the option at the very end of N/A. So if your focus is nonclinical, you have the option of then selecting N/A under target diagnosis so that that would correspond. I also want to point out that if you select a clinical focus for the plan, then there is an additional element that will be available for you to enter, and that will be the benchmark, which you would fill out only if you selected a clinical focus.

I also want to emphasize that what we are doing today in the training is just a very quick high-level overview, and there will be significantly more information made available to you through the technical document, the QIP User Guide, as well as other supporting training materials that we will provide to you both on the quality website as well as through the HPMS module. Under section B-8, which is a section that will only appear on screen for MMPs, this does not pertain to MA plans at all. We have some additional data elements. You need to select the impact on the member, and you can check all that apply, and if there happens to be an additional type of impact on members you can select 'other' and then complete the text box there. You also need to complete the text box for anticipated outcomes, and rationale for selection. The character limit on these text boxes is 1500.

I also want to point out that there are some additional data elements for MMPs to complete under section E, which is the planned interventions section. Specifically, MMPs must provide the

planned intervention timeframe, inclusion criteria, and target audience. They must also identify anticipated barriers for planned interventions and provide potential mitigation plans. If you'll flip to the next slide, all of these additional data elements are text fields and have a 1500 character space limit on them. These items will need to be completed for all of the interventions that are identified and as mentioned previously, you can have up to three interventions.

Here is a link that we are providing for the MMP QIP templates. They will be located on the MA quality page. As previously mentioned, the User Guide will be made available through the HPMS module. The expected tentative release date for the MMP QIP User Guide is October 28, 2016.

If you have any questions, you can submit those through the MMCO Caps Model email address, which I've provided to you there. Just so that you know, I am the person who responds to all of the emails received through that mailbox and when I respond to you, I will provide my direct email at CMS if there are any additional questions or follow-up that's needed.

I also wanted to indicate that we do have a QIP Plan Section Q&A session scheduled, that is scheduled for October 26 from 2 to 3 PM ET. The details are provided in the HPMS memo training for 2016 Quality Improvement Project Plan Section submission, which was released on September 23. Please refer to that document for additional information. Thank you very much.

Thank you, Betsy. I just want to reiterate that the information that Betsy gave us during the presentation is solely related to MMP plans. So again thank you, Betsy, and also for providing some of the reminders. The question and answer session for the QIP Plan Section is scheduled for October 26 and that is 2-3PM EST. The link for that discussion was provided in the HPMS memo. In addition, we are back to the MA QIP and CCIP resources. If you submitted a question today that we did not answer, we will answer your question then. Or please feel free to submit it to the Medicare Part C Policy Mailbox. That is under the resources and it's the last reference on this slide – that's the [dpap.lmi.org](http://dpap.lmi.org). We will be compiling questions, and over the next few weeks please submit questions. So that we can respond to them as well as take additional questions during the question and answer session. Then again, one last reminder, the Annual Update training session will be scheduled for early December, and we will provide you with a training date for that in an upcoming HPMS memo, as well as update the resources on the MA quality program website with the Annual Update requirements.

We would like to thank you all for joining us, we hope this was helpful and please feel free to reach out to us with questions, and we hope you have a great day. Thank you so much.