

Medicare Advantage

Quality Improvement Project (QIP) and
Chronic Care Improvement Program (CCIP)

Resource Document 2016

Table of Contents

General Overview and Regulatory Authority.....	2
QIP and CCIP Reporting Requirements.....	2
Mandatory QIP Topic.....	3
Summary of QIP Requirements.....	4
QIP Discussions.....	5
QIP Communication Tool.....	5
Appendix A: QIP Plan Section.....	6
Appendix B: QIP Annual Update (Reserved)	11
Mandatory CCIP Topic.....	12
Summary of CCIP Requirements.....	12
Appendix C: CCIP Plan Section.....	13
Appendix D: CCIP Annual Update (Reserved).....	15
Appendix E: Glossary.....	16
Appendix F: Additional Resources.....	18

General Overview and Regulatory Authority

All Medicare Advantage Organizations (MAOs) must conduct a Quality Improvement Project (QIP) and a Chronic Care Improvement Program (CCIP) as part of their required Quality Improvement (QI) Program described at 42 CFR §422.152. MAOs must conduct a QIP and a CCIP for each contract. The QIP and CCIP should cover all the non-special needs coordinated care plans, including Medical Savings Account Plans (MSAs) and Private Fee for Service Plans (PFFS) with contracted networks offered by the MAO.

MAOs must also conduct a separate QIP and CCIP for each type of Special Needs Plans (SNP) offered under each contract. For example, if a MAO offers multiple Dual-eligible SNPs (D-SNPs) under a single contract, the MAO must identify and implement a D-SNP QIP and a D-SNP CCIP covering all the D-SNP offerings under contract.

QIP and CCIP Reporting Requirements

QIPs and CCIPs have two parts: (1) the Plan Section, which describes how the QIP/CCIP will be implemented, and (2) the Annual Update, which describes the MAO's progress in implementing the QIP/CCIP. MAOs are only required to submit the QIP(s) to the Centers for Medicare & Medicaid Services (CMS). **The CCIP Plan Section or Annual Updates do not need to be submitted to CMS.** However, it is CMS's expectation that MAOs will implement and/or continue with their current CCIP(s) as required by the MA Quality Improvement Program regulations. MAOs should document the implementation of the CCIP in a manner sufficient for tracking progress and results. See appendices C and D for descriptions of the minimum CCIP Plan Section and Annual Update requirements.

QIP Plan Section Submissions

All contracts and SNPs that are newly-offered in a contract year (CY) are required to submit an initial QIP Plan Section through the health plan management system (HPMS) for CMS review during the annual submission period. The QIP Plan section is comprised of the Plan component of the Plan, Do, Study, Act (PDSA) quality improvement model and outlines the overall structure for implementation and monitoring of the QIP.

CMS will determine the dates for Plan Section submission on an annual basis and notify MAOs through HPMS. All QIP Plan Sections will be reviewed by CMS using the requirements as outlined in Appendix A. An MAO whose Plan Section submission does not satisfy these requirements will be notified of the deficiencies through HPMS and a resubmission will be required. The resubmission must address the deficiencies identified in the HPMS notification.

QIP Annual Update Submissions

The QIP Annual Updates must include the Do, Study, and Act components of the Plan Do Study Act (PDSA) quality improvement model and are essentially progress reports. MAOs must assess and document activities related to these quality initiatives on an ongoing basis and make modifications to interventions and/or processes as necessary. This information must be submitted to CMS as part of the Annual Update. CMS will provide MAOs with the dates for submitting the Annual Update annually through HPMS. The Annual Updates will be reviewed by CMS according to the requirements outlined in Appendix B. An MAO whose Annual Update does not satisfy these requirements will be contacted through HPMS and a resubmission will be required. The resubmission must address the deficiencies identified in the HPMS notification.

The Health Plan Management System (HPMS)

The HPMS QIP Module serves as the means for MAOs to report on their QIPs to CMS. The QIP module allows MAOs to report on the QIP throughout the entire life cycle of the QIP, and mirrors the PDSA quality improvement model. For information on how to access the QIP Plan and Annual Update sections in HPMS, please see the HPMS QIP Module User Guide located in the Quality and Performance module.

Mandatory QIP Topic-Promote Effective Management of Chronic Disease

New QIPs beginning in 2015, 2016 and 2017 are required to support effective management of chronic disease, as outlined in CMS's Quality Strategy Goals. Effective management of chronic conditions is expected to result in slowing disease progression, preventing complications and development of comorbidities, reducing preventable emergency room (ER) encounters and inpatient stays, improving quality of life for the enrollee, and saving costs for the plan and the enrollee.

QIPs supporting effective management of chronic conditions must be implemented over a three-year period and designed to improve enrollee health outcomes and satisfaction, and result in measurable outcomes. The aim of this mandatory topic is to:

- Align with the CMS Quality Strategy found on the CMS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html>
- Include interventions that are above and beyond MA plans' inherent care coordination role and overall management of plan enrollees;
- Engage enrollees as partners in their care;
- Increase disease management and preventive services utilization;
- Improve health outcomes;

- Be universally applicable to plans;
- Facilitate development of targeted goals, specific interventions and quantifiable, measurable outcomes;
- Guard against potential health disparities; and
- Produce best practices.

Plans will select a chronic condition from the diagnoses listed in Appendix A, Field B3. CMS included in the list chronic conditions that are less often targeted by plans for disease management programs. Plans may not select a condition that is currently being addressed in their Chronic Care Improvement Program (CCIP). Those conditions may be comorbidities for the enrollees targeted by the plans' QIPs, but are not to be the focus of the new topic.

CMS expects submissions to include some of the following types of interventions:

- Care coordination to ensure enrollees receive care according to accepted standards of practice, i.e., clinical guidelines;
- Promote lifestyle changes and use of preventive services to slow the progression of disease and/or prevent development of complications and comorbidities;
- Effective disease management programs;
- Plan outreach to providers to establish partnerships/collaboration with providers, community groups and stakeholders to leverage resources;
- Effective communication across the care continuum; and
- Education and outreach interventions to engage enrollees and caregivers as partners in care.

Note: These are just a few examples of QIP interventions that CMS would expect to see and are not meant to be an all-inclusive list. The formulation of an MAO's QIP interventions should begin with a comprehensive analysis of the target population.

Summary of QIP Plan Section Requirements

The QIP Plan Section describes the overall plan for addressing the effective management of chronic disease, including the rationale for selection of the chronic condition, a description of the target population, as well as the target goal and the intervention(s) that the MAO will implement to achieve the goal. In identifying a goal, an MAO should determine a baseline as a point of reference by which to evaluate (i.e., measure, compare, judge) its progress or success. In addition, the MAO must identify a national standard or external benchmark that is appropriate for measuring achievement of its identified goal. The MAO also must describe the data source(s) it will use to measure the success of the project or program.

QIP Discussions

As MAOs are evaluating the effectiveness of implementation of their QIP initiatives, MAO staff are encouraged to discuss the progress as part of their ongoing/routine communications with their CMS Account Manager (AM). The following communication tool may be helpful to MAO staff responsible for tracking progress and communicating with their AM about their QIP quality initiatives. Use of the tool is optional and is intended to help MAO staff engage in their early discussions with their AM as well as internally to facilitate the PDSA quality improvement model. MAOs are encouraged to discuss other aspects as needed.

QIP Communication Tool

1. QIP Submission Complete? Yes/No? If No, identify areas of difficulty or where further discussion, clarification or information would be helpful.
2. Data Collection:
 - a. Target Chronic Condition: Data collected? Yes/No. If No, discuss and include any barriers or mitigation strategies.
 - b. Target Population: Identified and similar to anticipated population? Yes/No. If No, discuss and include any barriers and mitigation strategies.
 - c. Target Goal: Data collected? Yes/ No? If No, discuss and include any barriers or mitigation strategies.
 - d. Interventions: Data collected to support interventions: Yes/ No? If No, discuss and include any barriers or mitigation strategies.
3. Interventions initiated as planned? Yes/ No.
 - a. If Yes, discuss the implementation status and any available results for each intervention and include the following information:
 - i. How many enrollees in the target population received the intervention?
 - ii. How often is the intervention provided? For example, quarterly, semi-annually or ongoing.
 - b. If No, for each intervention, discuss and include any barriers, mitigation strategies or planned changes from the initial submission.
4. Best practices, lessons learned, other issues or comments the MAO would like to discuss with the CMS AM.

Appendix A

QIP Plan Section

A. Medicare Advantage Organization (MAO) Information

MAO-specific information is auto-generated and includes: MAO Name, Contract Number, Identification Number, Project Cycle, Quality Improvement Project Topic and Quality Contact Person.

B. Summary of QIP

B1. QIP Title

Enter the name of the QIP Title and ensure the title indicates the target chronic condition that will be the focus of the project (Character limit 200).

For example: Improve the Effective Management of Diabetes by Engaging Enrollees as Partners in their Care.

B2. Implementation Date

The system shall display January 2017.

B3. Target Diagnosis

From the drop down menu select one target chronic condition for which will serve as the focus of the QIP. Conditions marked with * may only be selected if they are not part of a current CCIP initiative. The drop down menu list the following chronic conditions choose from:

- *Atrial Arrhythmias
- Behavioral Health Condition-Anxiety Disorders
- Behavioral Health Condition-Bipolar Disorder
- Behavioral Health Condition-Depression
- Behavioral Health Condition-Major Depression
- Behavioral Health Condition-Schizophrenia
- Cancer
- Chronic Kidney Disease (CKD) Stages 4 or 5
- Chronic Obstructive Pulmonary Disease (COPD) and or Asthma
- *Congestive Heart Failure (CHF)
- *Coronary Artery Disease (CAD)
- Dementia
- *Diabetes
- End Stage Renal Disease (ESRD)
- HIV/AIDS

- *Hypertension
- Osteoporosis
- Parkinson Disease

B4. Description of QIP

Provide a brief/summarized description of the QIP, and include the (1) target chronic condition and (2) overall anticipated outcome(s), (3) rationale for selection, (4) target population, (5) planned interventions, (6) target goal, (7) how progress will be measured, and (8) the data source (i.e., claims data, HEDIS, etc.) (Character limit 1500).

For example: (1) The target chronic condition is diabetes.

(2) The overall anticipated outcome(s) are improvements in HbA1c control and reductions in hospital admissions.

(3) Approximately 20 percent of enrollees are identified as having diabetes, a leading cause of death in the United States. Many enrollees are not aware that they have diabetes or the associated risks of blindness, amputations or other comorbidities.

(4) An estimated 6,000 enrollees with diabetes will meet the inclusion criteria for the Target Population.

(5) Planned interventions to promote effective management of diabetes include: care coordination for enrollees at high risk of a hospital admission; enrollee education including health education materials; personalized information about test results; and plan outreach to providers, including reports about each enrollee's progress in following with clinical guideline recommendations.

(6) The target goals are increasing the percentage of enrollees in the target population with their HbA1c under control by 30% and reducing the number of inpatient hospital admissions per 1000 enrollees with diabetes by 20% each reporting period.

(7) Progress will be measured annually through HEDIS and claims and encounter data.

(8) The data sources for identifying enrollees with diabetes are claims, HEDIS criteria, and referrals by physicians and case managers.

B5. Clinical Guidelines Used to Shape QIP

Reference the clinical guidelines, standards of practice, etc., which will be used to guide or shape the QIP, as well as serve as the basis for the target goal, interventions, education and or other aspects (Character limit 1500).

For example: Sample guidelines include, but are not limited to, the American Diabetes Association, the United States Preventive Services Task Force, and the Institute for Clinical Systems Improvement (ICSI) Health Care Guide for Adult Depression Updated in September 2013.

C. Enrollee Population

C1. Total Enrollment

Provide the overall total number of enrollees in the plan at time of submission (Enter Number).

For example: Enter the numeric value of 45,000 if there are forty five thousand enrollees in the plan.

C2. Population Description

Provide: (1) The clinical and or demographic make-up of the QIP target population, the opportunity for improvement, and how 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 (Character limit 1500).

For Example: (1). Through claims data and other MAO data sources, we have identified that 20% of our population are diabetic, 10% have chronic kidney disease, and 30% of our enrollees have cognitive and/or behavioral health conditions. In addition, 25% of the population has some form of COPD and or asthma. Other notable characteristics of the plan population include low income levels and limited English proficiency.

Given the prevalence of diabetes within our plan population, we have determined that better HbA1c control is an opportunity for improvement and will help to prevent and/or delay the onset of complications associated with poor HbA1c control. We believe that the interventions developed for the target population are comprehensive and also aim to reduce hospital admissions and emergency department visits. The target population will also benefit from language appropriate materials as well as linkage to appropriate community resources.

(2). 6,000 enrollees with diabetes meet the QIP Target Population inclusion criteria.

D. Goal of QIP

D1. Target Goal

The target goal(s) must be a specific quantifiable outcome measure that is linked to the planned interventions and appropriate for the targeted chronic condition. If there is more than one target goal in your QIP plan, please list them numerically. Section D1 is divided into two parts:

Quantifiable Goal

Enter number and or percentage (Character limit 100).

For example: Increasing antidepressant medication adherence by XX%.

Description of goal

Provide a description of the goal (Character Limit 1500).

For example: Increasing the percentage of enrollees in the target population who remain on an antidepressant medication for both acute and continuation phases of treatment, by XX%, by the year 2019.

D2. Baseline

Provide an initial baseline measurement against which progress will be measured over the 3-year project cycle. This should be a quantifiable numeric indicator that directly ties to the measure articulated in the target goal section and will be measured using the data sources identified in D4 (Character limit 1500).

For example: The MAO will utilize the HEDIS measure for Antidepressant Medication Management as its baseline, which currently is at a rate of XX%. This baseline will be used for comparison in the QIP annual updates over the 3 year project cycle.

D3. National Standard (if applicable)

Reference a national standard or benchmark for the target goal if one is available. A best practice or nationally recognized framework may also be referenced here (Character limit 1500).

For example: The NCQA State of Health Care Quality 2014 Medicare HMO percentage rate for Acute and Continuation Phases of Treatment for Major Depression.

D4. Data Source(s) Used to Measure Goal (check all that apply)

- Medical Records
- Claims (Medical, Pharmacy, Laboratory)
- Appointment Data
- Plan Data (complaints, appeals, customer service)
- Encounter Data
- Health Risk Assessment (HRA) Tools
- Health Effectiveness Data Information Set (HEDIS®)
- Health Outcomes Survey (HOS)
- Consumer Assessment of Health Care Providers and Systems (CAHPS®)
- Surveys (enrollee, beneficiary satisfaction, other)

- Minimum Data Set (MDS) I-SNP
- Other (with this option, the user is given the opportunity to explain “other” data sources)

E. Planned Interventions

E1. Intervention Type (check up to 3)

- Provider Education
- Enrollee Education
- Medication Adherence
- Reward and Incentive Program
- Care Coordination
- Enrollee Outreach
- Plan Outreach to Providers
- Disease Management
- Home Visits
- Promoting Lifestyle Changes
- Other (may choose “other” up to 3 instances)

E2a. Description of Intervention

For each intervention, describe the planned intervention(s) in a clear and logical way. Be sure to show or indicate how the interventions will help to achieve the target goal and improve health outcomes (Character limit 1500).

For example: MAO Outreach to Providers--The MAO will provide clinical practice guidelines for management of congestive heart failure (CHF) on the website and send applicable primary care or specialty providers reports on their patients’ progress in meeting or not meeting clinical guidelines, medication adherence and achieving optimal test results. The MAO will also conduct provider education on the clinical guidelines for CHF and share resources including care management, telephonic outreach or other activities available to support the providers in caring for higher risk patients. This intervention will help the plan achieve the target goal(s) and improve enrollees’ health outcomes by facilitating effective communication between the MAO, the provider and the patient to assure each patient receives the appropriate level of care to improve their health and avoid negative health outcomes such as hospital admissions or medication adherence issues.

E3a. Measurement Methodology

For each intervention, provide the methodology that will be used to measure success, including, but not limited to: (1) How the data source(s) selected in D4 will be utilized; (2) The target population specific to each intervention; and (3) The quantifiable measurement of success for each intervention (Character limit 1500).

For example, Care Coordination: (1) Health Risk Assessment (HRA) tools, claims, and case management documentation will be used to identify the enrollees with CHF and collect data to measure the success of the intervention. (2) The target population will be enrollees with CHF that meet the inclusion criteria for Care Coordination. (3) The quantifiable measures of success for this intervention will be reductions in the number of inpatient hospitalizations and emergency room visits per 1000 enrollees with CHF, and the 2015 HEDIS rate for Annual Monitoring of Patients on Persistent Medications. The success of this intervention will be assessed annually.

Fields E2a and E3a will repeat as needed for up to 3 interventions.

Appendix B

QIP Annual Update-Reserved

Mandatory CCIP Topic-Million Hearts

The CCIPs are required to support the Department of Health and Human Service's Million Hearts by focusing on reducing cardiovascular disease over a five-year period. The goal of Million Hearts is to identify people at risk for heart attack or stroke, ensure they receive appropriate treatment, reduce the need for blood pressure and cholesterol treatment, promote healthy diet and physical activity, and support smoking cessation to reduce current and future cardiac risk. CCIPs must be clinically focused and should address some aspect of the ABCS of heart disease, which include:

A for appropriate aspirin therapy,
B for blood pressure control,
C for cholesterol management, and
S for smoking cessation.

For more information, visit the Million Hearts website at <http://millionhearts.hhs.gov/>.

Summary of CCIP Plan Section Requirements

The CCIP Plan Section describes the overall plan for addressing some aspect of the ABCS of cardiovascular disease, as described above. The Plan Section describes the target area (e.g., blood pressure) rationale for selecting that target area, the target population, as well as the target goal and the intervention(s) that the MAO will implement to achieve the goal. In identifying a goal, an MAO will determine a baseline as a point of reference by which to evaluate (i.e., measure, compare, or judge) the intervention's success. In addition, the MAO is to 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 goal. The MAO also must describe what data source(s) it will use to measure the success of the project or program.

Note: As mentioned earlier, MAOs are not required to submit CCIP Plan Section or Annual Updates to CMS. However, it is CMS's expectation that MAOs will implement and/or continue with their current CCIP(s) as required by the MA Quality Improvement Program regulations. MAOs should document the implementation of the CCIP in a manner sufficient for tracking progress and results. See appendices C and D for descriptions of the minimum CCIP Plan Section and Annual Update requirements.

Appendix C

CCIP Plan Section

I. Summary of CCIP

Title

The CCIP Title should indicate which aspect of the Million Hearts will serve as the focus of the project.

Implementation Date

The implementation date for a CCIP Plan Section developed in CY 2016 will be January 2017.

II. Description of CCIP

Provide a brief/summarized description of the CCIP, and include the (1) target area selected for the CCIP focus, (2) overall anticipated outcome(s), (3) rationale for selecting the focus area, (4) target population, (5) planned interventions, (6) target goal, (7) how progress will be measured, and (8) the data source (e.g., claims data, HEDIS, etc.).

Clinical Guidelines Used to Shape CCIP

Reference the clinical guidelines, standards of practice, etc., which will be used to guide or shape the CCIP, as well as serve as the basis for the target goal, interventions, education and/or other aspects.

III. Enrollee Population

Total Enrollment

Provide the overall total number of enrollees in the plan at time of CCIP development.

Population Description

Provide: (1) The clinical and or demographic make-up of the entire enrollee population, the opportunity for improvement, and how implementation of the CCIP will improve health outcomes for the target population; and (2) The estimated number of enrollees that meet the inclusion criteria for the CCIP initiative.

IV. Goal of CCIP

Target Goal

The target goal(s) must be a specific quantifiable outcome measure that is linked to the planned interventions and appropriate for the targeted chronic condition. If there is more than one target goal in your CCIP plan, please list them numerically. This section is divided into two parts:

Quantifiable Goal

Provide a number and/or percentage.

Description of goal

Provide a description of the goal.

Baseline

Provide an initial baseline measurement against which progress will be measured over the 5-year project cycle. This should be a quantifiable numeric indicator that directly ties to the measure articulated in the target goal section and will be measured using the MAOs' data source(s).

National Standard (if applicable)

Reference a national standard for the target goal if one is available. A best practice or nationally recognized framework may also be referenced here.

Data Source(s) Used to Measure Goal (check all that apply)

- Medical Records
- Claims (Medical, Pharmacy, Laboratory)
- Appointment Data
- Plan Data (complaints, appeals, customer service)
- Encounter Data
- Health Risk Assessment (HRA) Tools
- Health Effectiveness Data Information Set (HEDIS®)
- Health Outcomes Survey (HOS)
- Consumer Assessment of Health Care Providers and Systems (CAHPS®)
- Surveys (enrollee, beneficiary satisfaction, other)
- Minimum Data Set (MDS) I-SNP
- Other

V. Planned Interventions

Intervention Type(s)

- Provider Education
- Enrollee Education
- Medication Adherence
- Reward and Incentive Program

- Care Coordination
- Enrollee Outreach
- Plan Outreach to Providers
- Disease Management
- Home Visits
- Promoting Lifestyle Changes
- Other

Description of Intervention

For each intervention, describe the planned intervention(s) in a clear and logical way. Be sure to show or indicate how the interventions will help to achieve the target goal and improve health outcomes.

Description of Educational Efforts

Describe the type of education that will be implemented as part of the CCIP. Be sure to indicate the topic(s) as well as the intended audience, for example, provider, enrollee, caregiver etc.

Measurement Methodology

For each intervention, provide the methodology that will be used to measure the success of each intervention including, but not limited to: (1) How the data source(s) will be utilized; (2) The target population specific to each intervention; and (3) The quantifiable measurement of success for each intervention.

Appendix D

CCIP Annual Update--Reserved

Appendix E

Glossary

Action Plan

A defined or organized process or steps taken to achieve a particular goal or to reduce the risk of future events.

Barrier

An obstruction or something that impedes; anything that prevents progress or makes it difficult to achieve the desired goal or expected outcome.

Baseline

A baseline is information found at the beginning of a study or other initial known value which is used for comparison with later data.

Chronic Care Improvement Program (CCIP)

A set of interventions designed to improve the health of individuals who live with multiple or severe chronic conditions, and includes patient identification, monitoring and the use of evidence-based practice guidelines and patient self-management techniques. Other programmatic elements may include collaborative partnerships with providers, community resources and other stakeholders.

Evidence-based Medicine

The practice of making clinical decisions using the best available research evidence, clinical expertise, and patient values.

Inclusion and Exclusion Criteria

Defined parameters used to determine whether an enrollee may or may not be eligible to participate, either actively or passively, in the program/project or particular intervention.

Intervention

The Agency for Healthcare Research and Quality (AHRQ) defines intervention as, “A change in process to a health care system, service, or supplier, for the purpose of increasing the likelihood of optimal clinical quality of care measured by positive health outcomes for individuals.”

Methodology

The means, technique, procedure, or method used to collect data or measure the effectiveness of a program/project or intervention.

Plan, Do, Study, Act (PDSA)

A quality improvement model that is cyclical in nature and includes planning, implementing, studying a change, and acting on the results of that change.

Quality Improvement Project (QIP)

An organization's initiative that focuses on specified clinical and non-clinical areas to improve enrollee satisfaction and health outcomes ([Publication 100-16 Medicare Managed Care Manual, Chapter 5](#)).

Mitigation Plan

A timely action to correct and prevent significant suspected or identified systemic problems or barriers that could prevent the goal from being reached.

Special Needs Plan (SNP)

An MA coordinated care plan that limits enrollment to special needs individuals who are (1) institutionalized, (2) dually eligible for Medicare and Medicaid, or (3) diagnosed with a severe or disabling chronic condition ([Publication 100-16 Medicare Managed Care Manual, Chapter 16b](#)).

Target Population

A selected group of MA plan members that meet eligibility criteria for participation in a QIP.

Appendix F

Additional Resources

MA Quality Improvement Program Website

<https://www.cms.gov/Medicare/Health-Plans/Medicare-Advantage-Quality-Improvement-Program/Overview.html>

CMS Quality Strategy Goals

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html>

HPMS QIP Module User Guide

<https://hpms.cms.gov/app/login.aspx?ReturnUrl=%2fapp%2fhome.aspx>

HPMS log-in > Quality and Performance > QIP > Documentation > User Guide

HPMS Helpdesk or 1-800-220-2028

hpms@cms.hhs.gov

Questions--Medicare Part C Policy Mailbox (website)

<https://dpap.lmi.org>