Medicare Advantage

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

Resource Document 2017/2018

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General Overview and Regulatory Authority

Section 1852(e) of the Social Security Act requires that Medicare Advantage organizations (MAO) have an ongoing Quality Improvement (QI) Program. All MAOs must conduct a Quality Improvement Project (QIP) and a Chronic Care Improvement Program (CCIP) for each contract as part of their required QI Program described at 42 CFR §422.152. The QIP and CCIP should cover all non-special needs coordinated care plans, including medical savings account (MSA) plans and private-fee-for-service (PFFS) plans with contracted networks.

MAOs must also conduct a separate QIP and CCIP for each type/sub-type of special needs plan (SNP) offered under each contract. For example, if an MAO offers multiple dual-eligible SNPs (D-SNP) 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.

General QIP and CCIP Requirements

QIPs and CCIPs have two components: (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. All QIPs and CCIPs should follow the Plan, Do, Study, Act (PDSA) quality improvement model as the overall structure for implementation and monitoring.

Note that MAOs are no longer required to submit Plan Sections and Annual Updates to CMS. However, MAOs must conduct these initiatives as required by the MA Quality Improvement Program regulations. In addition, MAOs must assess and document activities related to these quality initiatives on an ongoing basis and modify interventions and/or processes as necessary. MAOs must make information on the status and results of ongoing projects available to CMS upon request.

The Health Plan Management System

The Health Plan Management System (HPMS) serves as the means for MAOs to submit attestations annually that they have an ongoing QIP and CCIP project. For information on how to submit a QIP and/or CCIP attestation, please see the HPMS CCIP/QIP User Guide located in the Quality and Performance module.

CCIP Requirements

CCIP Focus Area - Promote Effective Management of Chronic Disease

CCIPs must promote effective management of chronic disease, improve care and health outcomes for enrollees with chronic conditions, and be conducted over a three-year period. Effective management of chronic disease is expected to slow disease progression, prevent complications and development of comorbidities, reduce preventable emergency room (ER) encounters and inpatient stays, improve quality of life, and save costs for the MAO and for the enrollee.

The goals of the CCIP are to:

- Support the CMS Quality Strategy found on the CMS website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html;
- Include interventions that are above and beyond MAOs' inherent care coordination role and overall management of enrollees;
- Engage enrollees as partners in their care;
- Increase disease management and preventive services utilization;
- Improve health outcomes;
- Be universally applicable to MAOs;
- Facilitate development of targeted goals, specific interventions, and quantifiable, measurable outcomes;
- Guard against potential health disparities; and
- Produce best practices.

MAOs may select a chronic condition from the list in Appendix A (Section II, Target Chronic Condition); however, MAOs are not required to choose from this list. MAOs may choose other chronic conditions not included in Appendix A, provided they are appropriate to meet the needs of their enrollee population.

The formulation of an MAO's CCIP interventions should begin with a comprehensive analysis of the target population. See Appendices A and B for descriptions of the minimum CCIP Plan Section and Annual Update requirements. The list below includes, but is not limited to, intervention types CMS expects CCIPs to include.

- Care coordination to ensure enrollees receive care according to accepted standards of practice (i.e., clinical guidelines);

- Promotion of 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;
- MAO 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.

Appendix A

CCIP Plan Section

I. Summary of CCIP

CCIP Title
Document the CCIP Title and ensure that it includes the project's target chronic condition.

Implementation Date
Document the implementation date.

II. Target Chronic Condition

Identify a target chronic condition. Conditions may include, but are not limited to:

- 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's Disease
- Other Chronic Condition

Description of CCIP
Document a brief/summarized description of the CCIP, and include: (1) the target chronic condition, (2) the overall anticipated outcome(s), (3) rationale for selection, (4) the target population, (5) planned interventions, (6) the target goal, (7) how progress will be measured, and (8) the data source (i.e., 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 and serve as the basis for the target goal, interventions, education, and/or other aspects.

III. Enrollee Population

Total Enrollment
Document the total number of enrollees.

Population Description
Document: (1) The clinical and/or demographic make-up of the CCIP target population, the opportunity for improvement, and how the CCIP will improve health outcomes for the target population; and (2) The estimated number of enrollees and/or providers in the target population.

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. Document a description of the goal along with the specific number and/or percentage by which you will measure improvement.

Baseline
Document 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 identified in the target goal section and will be measured using the MAO's data source(s).

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.

Data Source(s) Used to Measure Goal (document all that apply)
Identify the data sources used to measure the specific goal. Potential data sources include, but are not limited to:

- 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-SNPs)
- Other

V. Planned Interventions

Intervention Type (document all that apply)
Identify the intervention type(s) that will be used to help achieve the target goal. Potential intervention type(s) include, but are not limited to:

- Provider Education
- Enrollee Education
- Medication Adherence
- Rewards and Incentives Program
- Care Coordination
- Enrollee Outreach
- Enrollee/Caregiver Engagement
- Plan Outreach to Providers
- Disease Management
- Home Visits
- Promotion of Lifestyle Changes
- Community Partnership(s)
- Other

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

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

Appendix B

CCIP Annual Update

I. DO Section

Timeframe
Document the project year. For example: Year 1 Annual Update.

Barriers Encountered (document all that apply)
If applicable, discuss any barriers that were encountered during the project year. Examples of barriers include, but are not limited to:

- Healthcare Team Issue(s)
- Communication Issues(s)
- Non-compliance
- Technology Issue(s)
- Medication Issue(s)
- Support System Issue(s)
- Transportation Issue(s)
- Financial Issue(s)
- Decline in Condition
- External Factor(s)
- Knowledge Deficit

Mitigation Strategies (document all that apply)
If applicable, discuss how you addressed the barriers. Examples of mitigation strategies include, but are not limited to:

- Care Management/Care Coordination
- Provider Outreach
- Culturally Appropriate Materials
- Increase Enrollee Family Engagement
- Information Technology Solutions
- Health Care Team Coordination
- Improve Communication
- Information Technology
- Post Hospital Discharge Care
- Link to Community Resources
- Other

II. Study Section

Results and Findings

In the Study Section, document details about the CCIP results and findings to date, including both quantitative and qualitative data. The results should include a comparison of the baseline to the target goal identified in the CCIP Plan Section and indicate whether or not the anticipated goal(s) and/or outcomes were achieved. Also, document your analysis of the results/findings for the related interventions.

Total Target Population

Document the total number of enrollees or providers in the CCIP target population.

Number of Enrollees or Providers Who Received Intervention(s)

Document the total number of enrollees or providers in the CCIP target population who actually received the intervention(s).

Results and/or Percentage

Document any quantitative and qualitative outcomes data on an annual basis (at a minimum), and as needed, including:

(1) The CCIP results and/or percentage data for each intervention;

(2) The numeric or percentage results comparing the target goal and baseline linked to each intervention; and

(3) The data source(s) and data collection period.

Note: For reliable and consistent measurement, CMS recommends MAOs use the same primary data source over time so that the findings are comparable.

Other Data or Results

Document additional outcome data or results pertinent to the project noting the source and data collection period.

Analysis of Results or Findings

Document an analysis of the CCIP results or findings, including achieved outcomes that relate to or accomplish the target goal. The analysis should also document how the intervention(s) helped to contribute or link to any degree of improvement.

III. Act Section

Next Steps & Action Plan

The Annual Update reflects progress to date as well as a snapshot in time. As such, the Action Plan may reflect modifications that have already occurred during the first year of implementation

(e.g., changes to the planned interventions), as well as proposed adjustments that will be implemented in the future. Document the Action Plan(s) based on the results and lessons learned to date, including:

(1) A description of the actual or proposed changes;

(2) The rationale for the changes and how the Action Plan will work towards achieving the project goal(s); and

(3) Whether or not these changes have already been implemented, or the plan for implementing these changes during the upcoming year.

Note: If the MAO has NO changes from the initial CCIP Plan Section, or the CCIP is on track to achieve planned outcomes, document this in the Action Plan Description.

Best Practices

Document any identified best practices that have resulted from the findings and have worked well in producing positive outcomes. Include a detailed description of any best practices including: (1) how the MAO identified these best practices(s); (2) how these best practices have or will impact the CCIP and expected results; (3) how the MAO will share the details of these best practices with others, and (4) how the MAO will or may implement these best practices going forward.

Lessons Learned

Document any identified lessons learned, either positive and/or negative, including a summary of how the lesson(s) learned during the reporting period impacted the results of the project, enrollees, providers, and/or other stakeholders.

QIP Requirements

QIP Focus Area- Improve Health Outcomes and/or Enrollee Satisfaction

QIPs must improve health outcomes and/or enrollee satisfaction, address one or more of the CMS Quality Strategy Goals, and be conducted over a three-year period. The goals of the QIP are to:

- Support the CMS Quality Strategy Goals found on the CMS website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html;
- Facilitate development of targeted goals, specific interventions and quantifiable, measurable outcomes;
- Guard against potential health disparities; and
- Produce best practices.

MAOs are given the flexibility to identify an area that supports the goals listed above and serves the needs of their enrollee population(s). See Appendices C and D for descriptions of the minimum QIP Plan Section and Annual Update requirements.

Appendix C

QIP Plan Section

I. Summary of QIP

QIP Title
Document the QIP Title and ensure that it includes the project's associating CMS Quality Strategy Goal(s).

Implementation Date
Document the implementation date.

II. CMS Quality Strategy Goal(s)

Identify one or more of CMS Quality Strategy Goals:

- Goal 1: Make care safer by reducing harm caused in the delivery of care.
- Goal 2: Strengthen persons and their families as partners in their care.
- Goal 3: Promote effective communication and coordination of care.
- Goal 4: Promote effective prevention and treatment of chronic disease.
- Goal 5: Work with communities to promote best practices of healthy living.
- Goal 6: Make care affordable.

Description of QIP
Document a brief/summarized description of the QIP, and include: (1) the target CMS Quality Strategy Goal(s), (2) the overall anticipated outcome(s), (3) rationale for selection, (4) the target population, (5) planned interventions, (6) the target QIP goal, (7) how progress will be measured, and (8) the data source (i.e., claims data, HEDIS, etc.).

Clinical Guidelines Used to Shape QIP (if applicable)
Reference the clinical guidelines, standards of practice, etc., which will be used to shape the QIP and serve as the basis for the target goal, interventions, education and/or other aspects.

III. Enrollee Population

Total Enrollment
Document the total number of enrollees.

Population Description
Document: (1) The clinical and/or demographic make-up of the QIP target population, the opportunity for improvement, and how the QIP will improve health outcomes and/or increase satisfaction for the target population; and (2) The estimated number of enrollees and/or providers in the target population.

IV. Goal of QIP

Target Goal
The target goal(s) must be a specific quantifiable outcome measure that is linked to the planned interventions and appropriate for the project focus. Document a description of the goal along with the specific number and/or percentage by which you will measure improvement.

Baseline
Document 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 identified in the target goal section and will be measured using the MAO's data source(s).

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.

Data Source(s) Used to Measure Goal (document all that apply)
Identify the data sources used to measure the specific goal. Potential data sources include, but are not limited to:

- 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-SNPs)
- Other

V. Planned Interventions

Intervention Type (document all that apply)
Identify the intervention type(s) that will be used to help achieve the target goal. Potential intervention type(s) include, but are not limited to:

- Provider Education
- Enrollee Education
- Medication Adherence
- Rewards and Incentives Program

- Care Coordination
- Enrollee Outreach
- Enrollee/Caregiver Engagement
- Plan Outreach to Providers
- Disease Management
- Home Visits
- Promotion of Lifestyle Changes
- Community Partnership(s)
- Other

Description of Intervention

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

Measurement Methodology

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

Appendix D

QIP Annual Update

I. Do Section

Timeframe
Document the project year. For example: Year 1 Annual Update.

Barriers Encountered (document all that apply)
If applicable, discuss any barriers that were encountered during the project year. Examples of barriers include, but are not limited to:

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- Communication Issues(s)
- Non-compliance
- Technology Issue(s)
- Medication Issue(s)
- Support System Issue(s)
- Transportation Issue(s)
- Financial Issue(s)
- Decline in Condition
- External Factor(s)
- Knowledge Deficit
- Other

Mitigation Strategies (document all that apply)
If applicable, discuss how you addressed the barriers. Examples of mitigation strategies include, but are not limited to:

- Care Management/Care Coordination
- Provider Outreach
- Culturally Appropriate Materials
- Increase Enrollee Family Engagement
- Information Technology Solutions
- Health Care Team Coordination
- Improve Communication
- Information Technology
- Post Hospital Discharge Care
- Link to Community Resources
- Other

II. Study Section

Results and Findings

In the Study Section, document details about the QIP results and findings to date, including both quantitative and qualitative data. The results should include a comparison of the baseline to the target goal identified in the QIP Plan Section and indicate whether or not the anticipated goal and/or outcomes were achieved. Also, document your analysis of the results/findings for the related interventions.

Total Target Population

Document the total number of enrollees or providers in the QIP target population.

Number of Enrollees or Providers Who Received Intervention(s)

Document the total number of enrollees or providers in the QIP target population who actually received the intervention(s).

Results and/or Percentage

Document any quantitative and qualitative outcomes data on an annual basis (at a minimum), and as needed, including:

(1) The QIP results and/or percentage data for each intervention;

(2) The numeric or percentage results comparing the target goal and baseline linked to each intervention; and

(3) The data source(s) and data collection period.

Note: For reliable and consistent measurement, CMS recommends MAOs use the same primary data source over time so that the findings are comparable.

Other Data or Results

Document any additional outcome data or results pertinent to the project noting the source and collection period.

Analysis of Results or Findings

Document an analysis of the QIP results or findings, including achieved outcomes that relate to or accomplish the target goal. The analysis should also document how the intervention(s) helped to contribute or link to any degree of improvement.

III. Act Section

Next Steps & Action Plan

The Annual Update reflects progress to date as well as a snapshot in time. As such, the Action Plan may reflect modifications that have already occurred during the first year of implementation (e.g., changes to the planned interventions), as well as proposed adjustments that will be implemented in the future.

Document the Action Plan(s) based on the results and lessons learned to date, including:

(1) A description of the actual or proposed changes;

(2) The rationale for the changes and how the Action Plan will work toward achieving the project goal(s); and

(3) Whether or not these changes have already been implemented, or the plan for implementing these changes during the upcoming year.

Note: If the MAO has NO changes from the initial QIP Plan Section, or the QIP is on track to achieve planned outcomes, document this in the Action Plan Description.

Best Practices

Document any identified best practices that have resulted from the findings and have worked well in producing positive outcomes. Include a detailed description of any best practices including: (1) how the MAO identified these best practices(s); (2) how these best practices have or will impact the QIP and expected results; (3) how the MAO will share the details of these best practices with others, and (4) how the MAO will or may implement these best practices going forward.

Lessons Learned

Document any identified lessons learned, either positive and/or negative, including a summary of how the lesson(s) learned during the reporting period impacted the results of the project, enrollees, providers, and/or other stakeholders.

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 or providers that meet eligibility criteria for participation in a CCIP or 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 CCIP /QIP User Guide
https://hpms.cms.gov/app/login.aspx?ReturnUrl=%2fapp%2fhome.aspx

HPMS Help Desk
hpms@cms.hhs.gov or 1-800-220-2028

Questions--Medicare Part C Policy Mailbox (website)
https://dpap.lmi.org