Slide 1

Hello Everyone,

Welcome to the Centers for Medicare & Medicaid Services (CMS) Quality Improvement Project (QIP) and Chronic Care Improvement Program (CCIP) open door forum. My name is Ellen Dieujuste and I am a Nurse Consultant working in the Division of Policy Analysis and Planning. I will be providing the content for the 1st section of today's presentation and then I will turn it over to my other Colleagues Heather Kilbourne and Donna Williamson.

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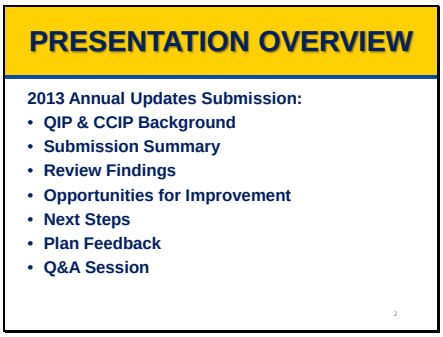

The purpose of today's presentation is to discuss the results of the 2013 Quality Improvement Project (QIP) and Chronic Care Improvement Program (CCIP) Annual Update submissions and our expectations regarding these ongoing initiatives.
We hope that the information presented today will help you in the development, implementation and ongoing activities related to the QIP and CCIP initiatives.
We will start the presentation with some background on QIPs and CCIPs and we recognize that most of you are familiar with this information but we want to review it for anyone newly working on the QIP/CCIP Annual updates. Next, we will provide a brief and general summary of the annual updates submissions. Then we will take a look at the findings from the Annual Updates. We also will review opportunities for improvement, next steps, and conclude the presentation with your feedback and Q&A.

There will be ample opportunity for organizations to provide feedback on the 2013 Annual Update submissions and ask questions.

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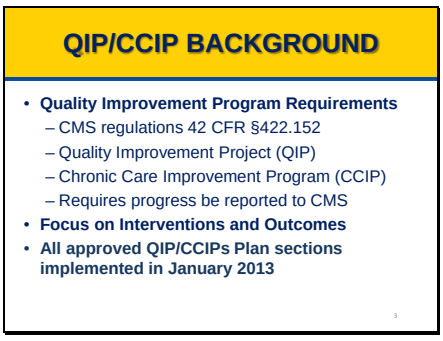

CMS regulations at 42 CFR §422.152 outline the quality improvement program requirements for MA plans.
Two key QI Program requirements are: 1) the development and implementation of a quality improvement project (QIP); and, 2) the development and implementation of a chronic care improvement program (CCIP).

The regulations also specify that plans will report their progress to CMS.

Both QIPs and CCIPs focus on interventions and outcomes.

The review findings discussed here today are based on the annual updates of QIPs and CCIPs that were approved in 2012 and implemented in January 2013.

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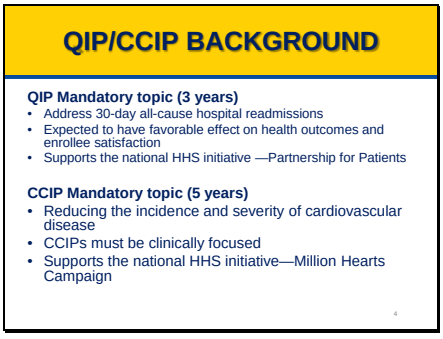

In 2012 CMS specified a mandatory QIP topic. All MAOs are required to address 30-day all-cause hospital readmission over a three year period. These efforts are expected to have a favorable effect on health outcomes and enrollee satisfaction. All QIPs support the national HHS initiative, Partnership for Patients.

One of the key components of the Partnership for Patients initiative is to decrease 30-day hospital readmissions, by improving care transitions. Over time, we believe that the QIP will be an important tool in helping MAOs develop interventions and establish best practices that are effective in reducing 30 day all-cause hospital readmissions.

The CCIPs are required to focus on reducing the incidence and severity of cardiovascular disease over a five-year period.

Must be clinically focused, and Support the Million Hearts Campaign, which 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 should address some aspect of the ABCs of heart disease, which have been identified thru the Million Hearts Campaign and include:

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

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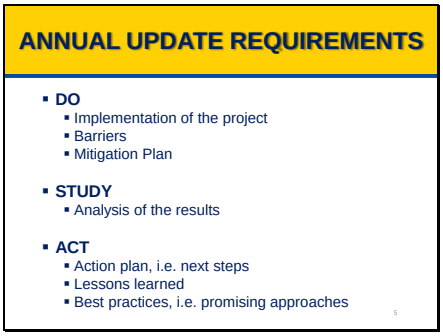

Let's briefly review the components of the Annual update. The Annual Update comprises information regarding the Do, Study, Act components of the quality improvement model.
At a high level:

- Do--Reflects the implementation of the project
- The barriers encountered, and
- The mitigation plan(s)
- Study—Reflects the results
- Act—Reflects lessons learned, best practices, action steps going forward, and those you have already taken during the first year of implementation.

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2013 ANNUAL UPDATE SUBMISSION SUMMARY

- 816 QIPs
- 819 CCIPs
- HPMS Technical Issues
- Submission window extension
- Most Annual Updates completed within the submission window
- Very small number of plans were required to resubmit

We reviewed a total of 816 QIP and 819 CCIP Annual Update submissions last year. We had a successful 1st Annual Update Review with a few minor challenges. Some of these include technical issues within the HPMS module. Given the technical issues we experienced with the Annual Update Submission in HPMS, we decided to extend the submission window by a week. A large majority of the Annual Update submissions were completed within the submission window. Only a very small number of plans were required to resubmit their Annual Updates, mostly due to the technical issues within HPMS.

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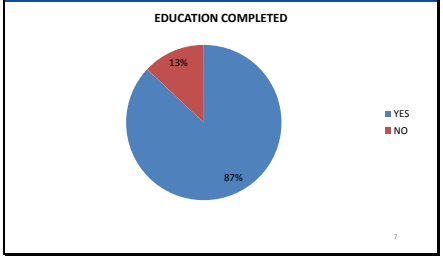
EDUCATION (CCIP Only)



SECTION OVERVIEW: We will now provide an overview of the required components of the Annual Update and pertinent information regarding each component. For the CCIP, the education information was auto-populated from the approved 2012 Plan section submission and the MAO was required to confirm if the education, as outlined in the approved plan section, was provided. This field required a yes or no response. If the answer was no, the MAO was required to explain why. Furthermore, the MAO was required to explain in detail the specific components of the education approach to be conducted going forward as part of the Act section.

REVIEW FINDINGS: 87% of plans sampled reported that they completed the education as outlined in the plan section. On the following slides, we will share some barriers encountered during the implementation period including barriers that prevented the education from being carried out as planned.

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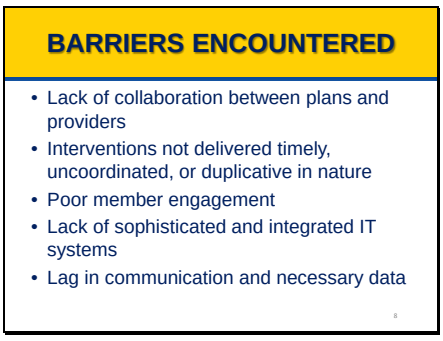

SECTION OVERVIEW: MAOS were to indicate whether or not any barriers were encountered during the initial Annual Update period by entering YES or NO. If no, then no further input was necessary. If yes, then the field was used to describe the actual barrier(s) encountered during the implementation of the project and to describe the impact of those barriers, including the effect on reaching the project goal.

Next, the MAO was to provide the mitigation strategies employed in response to any actual barriers encountered.

Review Findings: Out of sample of the Annual Update submissions reviewed, 96% of plans answered yes to the question "Did you encounter barriers" for QIP and 88% of plans answered yes to the question "Did you encounter barriers" for CCIP.

Some of the common barriers identified were:

- Lack of collaborative relationships between plans and providers resulting in interventions not delivered timely and or uncoordinated efforts, and inability to see the "big picture" of enrollee health status Because of the lack of collaboration, uncoordinated and duplicative efforts, some plans were not able to accurately assess the status and needs of the members following a hospital discharge. Admittedly, some members fell through the cracks and did not receive the care needed for an optimal transition.
- Difficulty contacting and engaging members, resulting in low participation rates (with disease management programs, home visits, compliance etc.)
- Population challenges, including poor lifestyle habits & little interest to change, resulting in limited success in achieving target goals
- Lack of sophisticated and integrated IT systems. Some of the specific items

mentioned include:

- New Software's inability to function as expected
- Lag in communications and necessary data

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BARRIERS ENCOUNTERED(Continued)

QIP	CCIP
Insufficient discharge planning	Medication and lifestyle non-adherence
Lack of social support	Leadership changes & staff turnover
Patient already enrolled in other programs	Low response from direct mailing intervention
Unable to Contact	

Other common barriers identified include:
QIP

- Insufficient discharge planning including failure to adequately assess patient's functional status, home condition, availability of family or companion, ability to obtain needed medications, supplies. And failure to assess whether or not they have transportation for follow-up visits.
- Lack of social support from family or caregivers
- Inability to obtain medications, perform self-care activities, and follow recommended diet.
- Some plans noted that members were already enrolled in CM and other programs internally, resulting in duplicative efforts and additional outreach to members who were already being contacted numerous times.
- Unable to contact member by phone or other mode for discharge follow-up and care coordination.

CCIP:

- Medication and lifestyle non-adherence: including not having a prescription filled, taking an incorrect dose, taking a medication at the wrong time, forgetting to take doses, or stopping therapy too soon. And other lifestyle non-adherence behaviors, such as failure to comply with

dietary recommendations, exercise, smoking cessation, or physical therapy.

- Many plans reported that changes in leadership/staff prevented or delayed implementation of their QIPs and CCIPs.
- Low response from direct mailing intervention-members are already inundated with marketing outreach and mailings from various other sources leaving educational mailings unread.

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Mitigation Strategies Utilized:

- Many MAOs revised their interventions because they failed to meet their goals, had low participation rates or because of other identified adverse outcomes such as those mentioned in the barriers encountered.
- Other plans refined their inclusion criteria to improve upon the identification and stratification of their population.
- Some plans noted the need to direct more focus to providers, and vice versa in terms of collaboration, education, follow-up, etc.

MAOs are also:

- Utilizing nurses and case managers to assess the status of the member and assist with care coordination especially for high risk and complex members.
- Increasing outreach and education—better coordination efforts between stakeholders (contracted providers, PBMs, 3rd party entities contracted to do case and/or disease management for the plans, community resources etc.)
- This last mitigation strategy specifically addresses the barrier of duplicating efforts for patients already enrolled in case management or other programs. Plans are integrating their outreach programs to reduce duplication of efforts.

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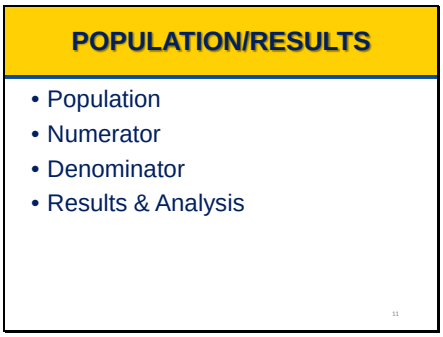

SECTION OVERVIEW: *The Total Population field* is where you provided the total number of enrollees in the plan(s).
Note that for non-SNP QIPs, the total population includes the aggregated number of enrollees in all applicable non-SNP coordinated care plans offered under the specified contract. The Numerator field is where you provided the number of plan members and/or data that met the inclusion criteria as defined in the Plan section and actually received the project intervention(s).The data in this field was reported as either a whole number or percentage.
The Denominator field is where you provided the total number of plan members and/or data eligible to participate in the program as defined in the Plan section. The data in this field was reported as either a whole number or percentage.

REVIEW FINGINGS: This section in HPMS is meant for plans and CMS to gauge participation. By looking at your total population, and the number of enrollees that you identified as eligible to participate versus the number of enrollees that do participate or receive some type of intervention, you can evaluate whether or not you are impacting your population appropriately. Some plans did use this data to try and reach more of their member population. We will look to

clarify our guidance surrounding this section for the 2nd Annual Update.

SECTION OVERVIEW: the *Results and/or Percentage* section is where you provided any data available at the time the update and indicated the data source and data collection period. THE *Other Data or Results f*ield is where you provided any additional data or results pertinent to the project.
The *Analysis of Results or Findings* is the area where you provided a description of the analyzed results to date including what was achieved in relation to the project goal and the significance of the demonstrated results.

REVIEW FINGINGS: Many plans provided their readmission rates with the data they had thus far for QIPs. In terms of the CCIPs, plans reported on screening rates, number of enrollees receiving educational interventions, and readmission rates if they were targeting specific diseases. These are just examples of some of the areas for which plans reported data. For the 2nd Annual Update, we expect to see improvements in specific measurements, and comparisons to the benchmarks. CMS will review your submissions to identify early successes and will be able to share those with you at a future call.

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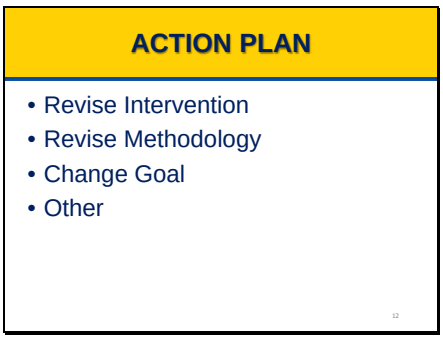
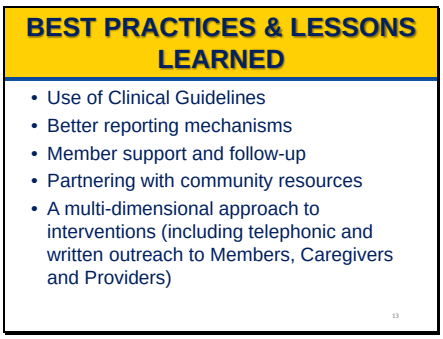


SECTION OVERVIEW: The *Action Plan* section is where you selected any Action Plan that your QIP/CCIP took in the implementation year as a result of the Study findings. Users had the option of selecting: *Revise Intervention*, *Revise Methodology*, *Change Goal*, or *Other*.
If any changes were made to the interventions, goals, or methodology identified in the Plan submission, an explanation of those changes was to be provided in the *Action Plan Description* and a brief description of how this revision helped to achieve the stated goal included.
Under the *Action Plan Description* you were to describe the selected Action Plan(s) and include how the next steps will be implemented as well as how this plan will work toward achieving the project goal.

REVIEW FINDINGS: Most plans selected more than one action plan based on their 1st year implementation results or identified barriers and there were several plans whose action plan options were not saved in HPMS due to a system error which was later corrected. Despite the technical issues here, most plans provided detail in the next field explaining their action plan, and identified revisions going forward, as a result of the barriers and lessons learned.

Slide 13



SECTION OVERVIEW: The *Best Practice Section* is where you discussed any identified Best Practices that have resulted from the findings and that have worked well in producing positive outcomes. If no Best Practice was found during the CY 2013 implementation year, you indicated "Not Applicable" in the field.
Under *Lessons Learned* you discussed any identified Lessons Learned, including a summary of how the interventions implemented during the CY 2013 implementation year impacted the results of the project, whether positive or negative.

REVIEW FINDINGS:
Majority of plans provided lessons learned thus far, and, some best practices that support Lessons learned and include:

- Promoting the use of clinical guidelines and the need for better provider engagement/setting clear expectations, and encouraging physician availability to discuss cases;
- The need for improved technology and reporting mechanisms to support clinical decisions, communications and coordination (of services amongst plans and providers);
- The need for regular follow-up with enrollees to support them in managing their diseases/mutual and realistic goal setting and promotion of behavioral changes;
- Extending partnerships into the community to help address unmet needs and improve outcomes; and
- Adopting a multi-dimensional approach to interventions (includes telephonic and written outreach to Members, Caregivers and Providers)

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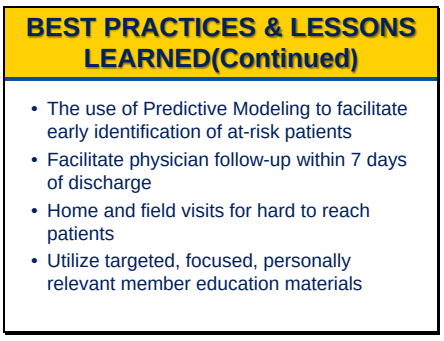

Other Lessons Learned:

- The use of Predictive modeling to facilitate early identification of at-risk patients
- Helping to coordinate physician follow-up within seven days of discharge as an intervention to help reduce re-admissions
- Home and field visits for hard to reach patients
- Utilizing targeted, focused, personally-relevant member education materials

This concludes the Annual Update review findings. Let's move to Opportunities for Improvement.

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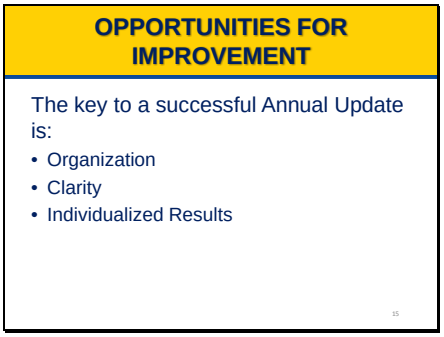


The key to a successful Annual Update is organization, clarity, and plan specificity. Submitting an Annual Update that is well-written is just as important as submitting an Annual Update with the appropriate data. In order to increase the value of Annual Updates going forward, we'd like to take this opportunity to share some ways in which MAOs can improve upon their QIP and CCIP Annual Update submissions. Our best advice is to keep your audience in mind while preparing your submissions. Providing a CMS reviewer with an organized, clear, and concise Annual Update will be less likely to result in questions or confusion and therefore will be less likely to require a resubmission.

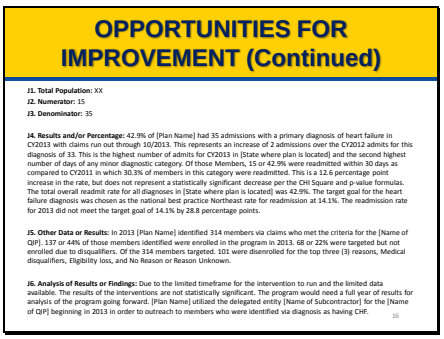
During our reviews, we found that the Study section was the most susceptible to this issue. We understand that you are conducting many projects and programs at once and have a lot of data to report and analyze. Therefore, it is very important to keep this data organized and to report it in such a way that is easy to understand so that progress can be easily tracked on an ongoing basis. Because we want the QIPs and CCIPs to be a collaborative process for both MAOs and for CMS, providing clear data analysis that is specific to each project and program

will help facilitate productive conversations with your Account Managers and the CMS Quality Team.

We also noticed through our review that many submissions were redundant and lacked variation. While MAOs may implement the same QIP or CCIP "Plan" for it's various contracts and SNP offerings, we expect the data and results to vary somewhat among the different projects. Annual Updates describe *actual* implementations and track *real* barriers and accomplishments. Because Annual Updates are based on real data, MAOs may **not** directly copy findings among their submissions. Instead, each Annual Update should be tailored to it's specific findings and the data analysis should reflect any variation or outcomes that result from each target population.

That being said, CMS does understand that MAOs using the same interventions throughout their contracts are likely to encounter *similar* results and maybe the same lessons learned among different projects. We also hope that, as the projects move forward, MAOs will implement any found Best Practices throughout their organizations as a whole. However, we urge MAOs to recognize the difference between "common" findings among different QIPs/CCIPs versus simply filing out each total population and then cutting and pasting the rest of the submissions.

Slide 16



This slide shows an example of a clear and organized QIP Study section taken directly from a CY2013 Annual Update submission. Please note that the MAO has presented ITS results using complete sentences and correct spelling and grammar. This makes it easier for the reviewer to read and to understand and will help both MAOs and CMS have better records going forward. Most importantly, the MAO has provided CMS with a concise written explanation of the numerical results. MAOs should be careful to fully explain their data so that CMS has a complete picture of the project's progress.

However, please also keep in mind that an overly complicated or verbose explanation will deter a reader almost as much as a scarce explanation will. Note that this MAO was able to provide a well-written, complete explanation while remaining well below the allotted 4,000 characters. We want to make sure that all MAOs understand that the character limit provided for the 2013 submissions was well above what we expected from each submission and was made larger only to ensure that *every* plan had ample room to provide their findings while taking into account all possible barriers, mitigation strategies, and any other plan specific scenarios no matter how unlikely. In other words, the designated character limit does not represent any sort of length requirement or expectation. Rather, we find that a well-organized and concise submission is better than an overly lengthy one. Using all or most of the character limit does not necessarily mean a better update.

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This slide shows an example of a CCIP Study section submission that needs improvement. Please note that the MAO has presented its results in an unclear and disorganized fashion. This submission does not provide written explanations of the numerical data and does not use complete sentences or correct spelling and grammar. It appears that the MAO cut and pasted clinical results.

While reviewing Annual Updates, we also noticed that many submissions were redundant and lacked variation. While MAOs may implement the same QIP or CCIP "Plan" for it's various contracts and SNP offerings, we expect the data and results to vary somewhat among the different projects and such nuances to be reported on an annual update-specific basis.

Plan sections consist of projected actions, hypothetical obstacles and projected goals. Annual Updates describe *actual* implementations and track *real* barriers and accomplishments. Plan sections are meant to present CMS with the QIP and CCIP processes and goals while the Annual Updates record the actual progress of those operationalized processes.

Because Annual Updates are based on real data, MAOs may **not** directly copy findings among their submissions. Instead, each Annual Update should be tailored to it's specific findings and the data analysis should reflect any variation or outcomes that result from each target population.

That being said, CMS does understand that MAOs using the same interventions throughout their contracts are likely to encounter *similar* results and maybe the same lessons learned among different projects. We also hope that, as the projects move forward, MAOs "may implement identified best practices across all its initiatives." However, we urge MAOs to recognize the difference between "common"

findings among different QIPs/CCIPs versus simply filling out each total population and then cutting and pasting the rest of the submissions.

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PROPOSED HPMS ENHANCEMENTS

- Eliminate redundancies
- Modify auto populated fields
- Decrease character limits
- Improve CMS' ability to analyze results
- Improve means to report results
- User guide revisions

Based on this first years' analysis of the Annual Updates, we are considering some proposed enhancements to the Annual Update module in HPMS for the 2014 submissions. However, we need to emphasize that, given budget limitations and priorities, these are only proposed enhancements. We cannot guarantee that all changes will be incorporated this year.

- As we move forward and begin preparing for the 2nd Annual Update this year, we would like to see more concise, and summarized information. Therefore, we are exploring how we can capture the most relevant information and eliminate, or at least reduce, some of the redundancies.
- We are considering modifying the auto-populated function as many of you have made changes to various aspects of your plans, resulting in outdated information in the auto-populated fields (e.g., interventions, education, target population etc.) .
- Also, we are considering decreasing the character limits. We believe this will minimize the burden for MAOs as well as CMS, it will facilitate more concise and summarized information, and it will assist us in performing a better analysis of the results. Please note that we encourage you to maintain your own detailed

documentation internally.

- CMS as an agency oversees many quality initiatives is very interested in seeing what all of you are doing related to your QIPs and CCIPs.
- Therefore, we are also exploring more simplistic means for plans to report their results, or at a minimum, reshaping our guidance to you so that the data/information you provide us in subsequent Annual Updates is easy to interpret.
- Some of the results reported by MAOs were rather complex and difficult to interpret. Some of you of you may have been contacted by your AM and asked to explain your results. At the conclusion of these 3 and 5 year efforts, we want to make sure that we are able to capture meaningful data, and accurately reflect your progress towards achieving quality improvement
- Any changes to HPMS as well as changes to the Annual Update guidance will be reflected in revisions to the HPMS User Guides

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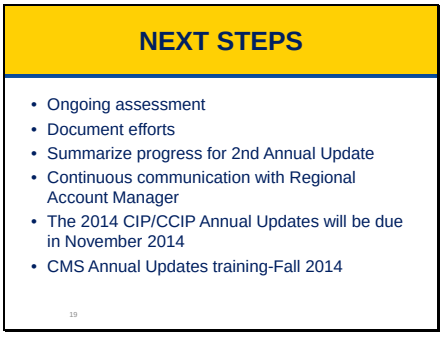

As we are in year 2 of implementation, we expect you continue to test your interventions and document progress, as well as lessons learned and best practices. If you find that you need to make modifications to your interventions, please note this, as it will assist you in providing the next annual update. This documentation will also help others in your health plan learn about the QIP/ CCIP, and should a change in staff occur, having updated and appropriate documentation will enable others to understand what has been done, and what they need to do to continue QIP/CCIP operations. Continuous evaluation and assessment will help you to continue to

identify barriers, what you did to mitigate those barriers and allow you to track your improvement.

Additionally, think about how you will summarize your progress and evolution for the second QIP/CCIP Annual Update, and Discuss your QIP/CCIP activities and progress throughout the year with your CMS Account Manager
The 2014 CIP/CCIP Annual Updates will be due in November 2014 (exact datesTBD), and reflect year two of QIP/CCIP Operations.

Training on the year 2 Annual Update requirements as well as any changes to HPMS will be in the fall 2014, in advance of the Annual Update submissions. Our goal is to make the Annual Update submissions less burdensome, yet, have the ability to capture meaningful data. Once we have a better idea of the enhancements that we can make to HPMS and revisions to the HPMS Users Guides, we will share that with you as soon as we can, in addition to the fall training.

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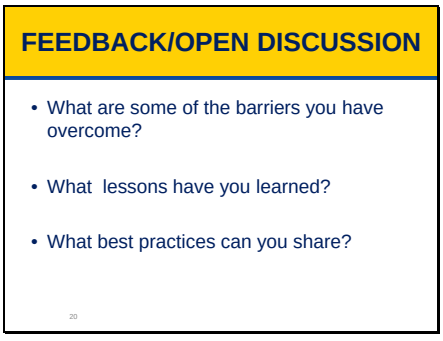

Before we move into questions and answers, we again want to emphasize that what we have provided you today is a very brief and limited sample of findings. We have more analysis to do. However, based on our reviews of the Annual Updates thus far, we see that many of you are taking some very progressive steps to overcome your barriers and build upon your lessons learned. We want to take the next few minutes to provide you with the opportunity to share your experiences as they relate to the barriers, lessons learned and best practices. We'd like to use this time as an opportunity to learn from each other.

We'll start with barriers:

Next, lessons learned,
Any best practices

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QUESTION & ANSWER SESSION

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QIP/CCIP RESOURCES

MA Quality Mailbox:
MAQuality@cms.hhs.gov

MA Quality Improvement Program Website:
http://www.cms.gov/Medicare/Health-Plans/Medicare-Advantage-Quality-Improvement-Program/Overview.html

QIP/CCIP HPMS User Guide:
https://gateway.cms.gov/

HPMS Help Desk :
800-220-2028
HPMS@cms.hhs.gov

We strongly encourage you to utilize these resources:

MA Quality Mailbox—for assistance with questions
MA Quality Improvement Website where you will find the
QIP/CCIP HPMS User Guide once updated
Finally, the HPMS Helpdesk-should be used for HPMS access issues and to update plan contact info.