2015 Medicare Advantage and Prescription Drug Plan Spring Conference & Webcast Transcript

QIP CCIP

Hi, thank you, Stacy, and good afternoon, everyone. Thanks for joining us after lunch. I hope you all had a nice lunch and enjoyed a break.

My name's Donna Williamson. I work in the Medicare Drug and Health Plan contract administration group and I'll be moving us into our next topic and that is quality improvement projects and Chronic Care Improvement programs, although I will note, and please let me apologize, the slide, where it says Chronic Care Improvement project should actually say Chronic Care Improvement program. But throughout the presentation we'll be referring to them as QIPs and CCIPs.

So today's presentation will include some background implementation and common approaches, 2014 annual update review findings, including barriers, mitigation strategies, best practices and lessons learned, and we'll briefly touch upon the 2014 annual update review findings -- I'm sorry, briefly touch upon the upcoming 2015 annual update season for submission.

We'll talk about the new QIP topic for 2016 and related resources, and we'll also have some time for questions and answers.

CMS regulations at 42CFR422-152 outline the quality improvement program requirements for MA plans. The two key program requirements include the development and implementation of a quality improvement project at QIP as well as the development and implementation of the Chronic Care Improvement Program or, again, the CCIP.

The regulations also specify that plans will report their progress to CMS and both QIPs and CCIPs focus on interventions and outcomes and utilize the planned due study act quality improvement model, also known as the PDSA or a PDSA cycle.

Back to the Top

In 2012, CMS specified a mandatory QIP topic. All plans are required to address 30-day all-cause hospital readmissions 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, or P for P. One of the key components of P for P is to decrease hospital readmissions by improving care transitions. We believe that the QIP is an important tool in helping MA plans develop interventions and establish best practices for achieving this goal.

The CCIPs are required to focus on reducing the incidence and severity of cardiovascular disease over a five-year period. CCIPs must be clinically focused and support million hearts, which identifies people at risk for heart attack or stroke and ensure that they receive appropriate treatment, reduce the need for blood pressure and cholesterol treatment, promote a healthy diet and physical activity, those life style changes, and support smoking cessation to reduce current and future cardiac risks.

So, in essence, CCIP should or must address some aspect of the ABCs of heart disease, which include A, for aspirin therapy, B, for blood pressure control, C for cholesterol management, and S for smoking cessation.

Annual updates reflect the progress of QIP and CCIP implementation. So, in other words, this is your progress report to CMS which we require you to submit annually.

For the 2014 annual update season, which was last fall, we reviewed a total of 892 QIPs as well as 892 CCIP annual update submissions. All annual updates are reviewed by CMS and largely done by the CMS regional office staff. So we want to thank them for all of their hard work for getting those reviews done, as well as providing feedback as necessary, and also thank you for submitting them. We understand that the submission season, it does fall right before Thanksgiving, as well as new plans sections, so we understand that you all work very hard to submit those. And then once you're done, then it is our job and we're very busy the month of December and early January making sure that, again, we review those annual update submissions.

The critical review elements that we use to review your annual update submissions include describing actual barriers and mitigations strategies, results and analysis of those results, and lessons learned and best practices, as well as an action plan going forward with any new planned strategies.

In terms of results, I did want to touch upon that very briefly and let you know that once the projects come to their three-year cycle -- so, for example, the QIPs that were implemented in 2013, they're now wrapping up for the end of this year, we're going to be able to do a more quantitative analysis once that project cycle has ended and then the same with the CCIP.

Back to the Top

So we understand and as we expect that once you go along and you implement and you have these lessons learned that you're refining your plans, perhaps you're changing your strategies, interventions, your target populations, in some cases you're changing your goals, so it's very difficult for us to have an apple-to-apple comparison, so, again, we think a better time to do that is at the end of a project cycle.

The most common approaches to QIPs has been some form of improving care transitions. Many of you are focusing on improving care transitions through outreach to enrollees and improving care coordination, with an emphasis on postdischarge care. So this means that enrollees are receiving follow-up primary care or PCP visits within seven days of hospital discharge and some of you are actually making those appointments, you're doing a lot of work around really facilitating, so you're arranging transportation or you're working with your contracted providers to perhaps extend those hours to really accommodate these enrollees because we know how important it is to make sure that enrollees are beginning followed up, especially after a hospitalization.

You all are focusing on home visits following the hospital discharge and community partnerships, extending partnerships into the county to help address unmet needs, leverage resources, and improve enrollee outcomes.

Other areas of emphasis include medication reconciliation and improving self-care management through disease management programs or perhaps other educational efforts. So some of you, you're really working with your providers or also doing alternative means for education, disseminating information in other ways.

Some of you are doing onsite classes, providing education through the Web or working with enrollees at provider offices.

Some of the common approaches to CCIPs include disease management strategies, which, again, promote self-management skills, teaching individuals and their caregivers on how to manage chronic diseases, controlling risk factors and promoting lifestyle modifications.

Also addressing specific clinical targets such as blood pressure and cholesterol control, medication adherence and focusing on the management of diabetes.

I know that some of you have a rather large diabetic population, so you're taking the opportunity to really, I'll say, assertively, work with your diabetics to make sure that they're getting all their preventive care and/or maintenance care to delay the onset or progression of cardiovascular disease, as well as other complications.

Other approaches for the CCIPs include care coordination. Again, improving care management, multidisciplinary teams, so you're really working internally to use those multidisciplinary teams to meet the needs of complex enrollees and facilitate the appropriate care.

Back to the Top

You're also reaching out to providers to educate and promote the use of evidence-based guidelines and also, again, to try and create partnerships through awareness of the program and setting mutual goals for chronic conditions.

A very common theme that we're seeing with these initiatives is partnerships. Through your annual updates, you are really emphasizing the need for partnerships with your providers, with caregivers, with enrollees and other community resources. However, striking a balance between partnerships and duplicating services takes some work, takes some coordination.

So moving on to barriers. Some of the common barriers that you all have been identifying those at the operational level, including available resources, qualified staff, robust IT systems, meaning that your systems are not functioning as you had, perhaps, anticipated or maybe there is a delay with the implementation of some of these systems, so what that's resulting in, you're not getting data that you need for timely interventions, and some members are admittedly falling through the cracks and not receiving the care that they need for an optimal transition.

So, again, the lag in timely data, lack of collaborative relationships, perhaps there's a lot of uncoordinated efforts or duplicative efforts and it's really -- what it's doing, it's creating an inability to really see the big picture of the enrollee health status.

You all have noted population challenges, including poor lifestyle habits, little interest to change. Also a lot of difficulty contacting and engaging members, low participation rates, especially with disease management programs or perhaps enrollees aren't letting your staff get into the home to do those home visits needed after a hospitalization or just lack or compliance with treatment plans or discharge instructions.

Also some plans have reported problematic relationships with vendors or unanticipated delays in having them do the work that they were contracted to perform.

So as you'll see in the next few slides, the mitigation strategy is the best practices and lessons learned really do -- have shown to overlap, so that's why they're all sort of included in these next three slides.

Back to the Top

So some of the best practices and lessons learned that you all are taking into consideration and putting into your plans going forward again, building and strengthening partnerships, leveraging available resources, both internally and externally, outreach to provider and community groups and better alignment with hospital discharge staff through various integrated activities, enhancing care coordination efforts, utilizing and making sure you have the appropriate staff to adequately assess and meet the needs of complex and/or high-risk enrollees throughout the continuum of care and engaging enrollees and their caregivers as soon as possible; for example, while they're still in the hospital. We've had some plans tell us that they really -- they want to get into the hospital when possible and when they're notified and then have the available information to do that. And if they have good relationships with the hospital staff, that they can actually go in, assess the patient or the enrollee and then really work with the discharge staff to make sure that all of the needs are met so it's a smooth transition before -- or before, while and, you know, while they're leaving the hospital and going back to the home setting.

Early referrals to case management and other available resources. Some of you, especially with your SNIP plans, you're really helping to arrange or coordinate financial help, for example, help with prescription drug copays, transportation, health education classes, really trying to, again, leverage what is in the community that we can use to help a seamless transition.

Home visits to do onsite assessment and education. Some of you have noted the use of health coaches or other disciplines to address lifestyle as well as medical and behavioral health needs.

We've seen a number of plans working on understanding some of the theories around behavioral change, or willingness to change and you're exploring various approaches to that to better work with enrollees. So, for example, motivational interviewing, how motivated or how willing are enrollees able to change their behavior so that they can perhaps get off of blood pressure medication or make dietary changes.

So also setting realistic goals with the enrollees and providers and really trying very hard to help members work around their barriers to success.

Some of the other best practices include enhancing IT systems for identifying gaps in care or preventive services, stratifying your populations to focus on the high-risk enrollees or perhaps broaden your target population.

So, for example, some of you are casting a wider net to increase the number of enrollees impacted by interventions.

Back to the Top

Predictive modeling. Again, to more accurately target your high-risk members, make projections and channel your resources appropriately. And many of you are working on staff education internal to the plan. So you are working to enhance methods for enrollee assessments, the motivational interviewing, helping people with behavioral changes, mutual goal setting, training around unique cultural beliefs or practices, and improved communication and how to effectively engage with enrollees or other stakeholders.

Those are just a few of the best practices and mitigation strategies that you all have noted in your annual updates. I really have a lot to say about these projects, but I have a very limited time, so I just wanted to really give you some key findings.

So shifting gears to the upcoming 2015 annual update season, we do anticipate that will, again, be in the fall of 2015. And, again, for those QIPs implemented in 2013, this will be your final annual update for your QIP.

So what that will mean is that we're really looking for you to summarize your results over the three-year period and we will be providing you training to make sure that you understand exactly what we're looking for, because at the end of these projects we really want to show how you all are improving care for your enrollees and that there's attribution here.

So, again, we really want to hear from you as to what your best practices are and what you have identified and will carry forward as you continue to manage your enrollee population and improve health outcomes.

If this is year one or two of your QIP implementation, we are looking for the same information; again, what's showing promising results and/or perhaps how you are modifying your strategies going forward.

Many plans have inquired about a new topic for 2016. And just to let you know, we are currently working on finalizing the new topic. However, we can tell you that we are using this criteria to help identify the new topic.

We want projects that are above and beyond the care coordination and overall management of plan enrollees. We believe the target population should be broader as some of you have conveyed this through your annual updates and you are actually already working to do that.

We want enrollees and caregivers engaged as partners in your car. And, of course, the topic should aim to improve health outcomes.

In addition, the topics should be universal or universally applicable to all plans; must include target goals, specific interventions and quantifiable outcome measures and have the potential to produce best practices and align with the CMS for the six quality strategy goals, which also align with the national quality strategy goals.

Back to the Top

Very quickly, those include safer care by reducing harm; strengthening person and family engagement as partners in their care; promoting effective communication and coordination of care; promoting effective prevention and treatment of chronic disease; work with communities to promote best practices of healthy living and making care more affordable.

I encourage you to use the available resources. Those include the MA quality mailbox, the MA quality improvement program website. We'll be making some updates to that. Whoops.

I'm sorry, I skipped a slide.

The resources should be at the end. I'm so sorry.

Okay. Let me go back to the resources. I apologize.

Getting back to the new topic. Sorry, my notes got a little mixed up. The new topic and other related information will be disseminated very soon by ways of an HBMS memo. We want to make sure that we get that to you as soon as possible so that you have ample time to prepare and also develop your 2016 planned section submissions again for the new QIP topic. And we are planning on providing necessary training related to the new topic requirements as well as trainings on the new QIP module in HPMS as well as the user guides.

We will notify you of those dates once they become available. And we've also gotten some inquiries about changes to the HPMS module, specifically the QIP and we are looking to make that more streamlined, and this is really a good opportunity for us to do that, especially since it is a new topic, but we're looking for more summarized information, more concise and perhaps we're looking for some dropdown so that we can better quantify your data and we're certainly looking for less text. Again, concise and summarized information.

Okay, so I apologize. So available resources, the quality mailbox, the MA quality improvement program website, as well as the QIP and CCIP user guides.

Okay, do we have any inhouse questions for Donna?

Hi, I'm Sandy Makolvey with Humana.

Oh, hi.

Hi.

I know your name.

I know. I know yours; thank you.

Back to the Top

I have a couple quick questions. So with this being the third year, the wrapup, for those that were implemented in 2013, do you know yet if the template, the QIP template, is going to have new fields or new user guide guidance around what kind of a wrapup, a summary, you know, bullet points you'll be looking for as we summarize the results?

Yes, absolutely. We are hoping. We can never say definitively, but we are hoping to make some enhancements to the third-year annual update again, so that we can really capture quantitative information. However, as we work on those and our developer makes that changes in HPMS, those really won't be available until the fall, but we're going to make sure that we do training so that you all know what to expect for the -- for your final annual update submission.

Okay. And then the other question I had is with regard to the dual demonstration projects that were implemented this year.

Okay.

Can you say anything about the collaboration between CMS and the states as you review these studies? It seemed a little disjointed or we weren't even really sure how that was going to happen last year till really almost up to the final date. So can you speak to that a little bit? Will both entities be reviewing the studies and weighing in and approving them?

Well, that's a good question. Unfortunately, we don't have the staff here today. The way that we've set that up, M-KEG, and the quality team that's here today, we actually -- we are managing and overseeing the QIPs and CCIPs for the MA and the SNIP plans, but -- so we understand that the requirements are the same for the duals projects, but the more specifics surrounding those dual projects, they're actually managed by another component within CMS, and that's the duals office, so I would be happy, Sandy, to let them know that you have some questions for them. Or if you want to e-mail me directly or through the quality mailbox with those questions, I'll be sure and forward those on to the dual's office.

Okay, all right, thank you.

You're welcome.

Okay, we are out of time for questions today, so thank you, Donna, for your presentation, and we will go ahead and do evaluations.

Back to the Top