Medicare Advantage

Chronic Care Improvement Program Resource Document

Updated 2020

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Statutory and Regulatory Authority

All Medicare Advantage (MA) organizations (MAOs) must have an ongoing Quality Improvement (QI) Program, as required by section 1852(e) of the Social Security Act (the Act) and 42 CFR § 422.152(a). The QI Program includes a Chronic Care Improvement Program (CCIP) that meets the requirements of § 422.152(c) for each contract. The CCIP should cover all non-special needs coordinated care plans, including medical savings account (MSA) and private-fee-for-service (PFFS) plans with contracted networks. MAOs should also conduct a separate CCIP for each type/sub-type of special needs plan (SNP) offered under each contract.

General Overview

CCIPs have two components:

- **The Plan Section**
    - The Plan Section describes the criteria for the CCIP, including the methodology used for identifying participants, mechanisms for monitoring participants, and performance assessments (42 CFR § 422.152(c)(1)); and
- **The Annual Update**
    - The Annual Update describes the MAO's progress in implementing the CCIP, including systematic and ongoing follow-up (42 CFR § 422.152(c)(1)(iv)). The MAO must also report status and updates to CMS as requested (42 CFR § 422.152(c)(2)).

MAOs must conduct the activities described in the Plan Sections and Annual Update sections as required by § 422.152, but there is no requirement to submit them to CMS. In addition, MAOs should assess and internally document activities related to these quality initiatives on an ongoing basis, as well as modify interventions and/or processes as necessary. MAOs must make information on the status and results of ongoing projects available to CMS upon request (42 CFR § 422.152(c)(2)). Model templates for both CCIP components are available for reference in Appendices A and B.

As a best practice, MAOs should follow the Plan, Do, Study, Act (PDSA) quality improvement model as the overall structure for implementation and monitoring of the CCIP.

The Health Plan Management System

MAOs must use the Health Plan Management System (HPMS) to report the status of their CCIP to CMS by December 31 annually. Submissions include an attestation by the MAO regarding its compliance with the ongoing CCIP requirement (42 CFR § 422.152(c)(2)). Refer to the HPMS CCIP/QIP MA Quick Reference Guide located in the Quality and Performance – CCIP/QIP Attestations module for more information.

CCIP Requirements

CCIP Focus Area - Promote Effective Management of Chronic Disease

The statutory and regulatory intent of the CCIPs includes the promotion of effective chronic disease management and the improvement of care and health outcomes for enrollees with chronic conditions. Effective management of chronic disease can achieve positive outcomes, including: slowing disease progression, preventing complications and development of comorbidities, reducing preventable emergency room (ER) encounters and inpatient stays, improving quality of life, and cost savings for the MAO and the enrollee. CMS recommends MAOs conduct CCIPs over a three-year period.

The CCIP is intended to achieve the following objectives:

- Support the CMS Quality Strategy found on the CMS website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Legacy-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 must develop a methodology to identify enrollees with multiple or sufficiently severe chronic conditions who would benefit from participating in the CCIP (or providers of such enrollees) as the target population. MAOs may select a chronic condition from the list (section II, Target Chronic Condition) in Appendix A. However, MAOs are not restricted to this list, and may choose other chronic conditions not included in Appendix A. The conditions in an MAO's CCIP should be appropriate to meet the needs of its enrollee population and be tied to the target population.

MAOs should conduct a comprehensive analysis of its target population in order to develop meaningful CCIP interventions. The non-exhaustive list below includes examples of intervention types that should be in CCIPs:

- 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

MAOs must develop criteria for the CCIP that meet the regulatory requirements (42 CFR § 422.152(c)(1)(i-iii)) and are consistent with an effective CCIP to serve enrollee needs (75 FR 19756 through 19757 and 80 FR 7935 through 7936). However, MAOs may target additional populations or conditions with their programs. CMS evaluates CCIPs using the following standards:

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

Develop criteria to identify MA enrollees with multiple or sufficiently severe chronic conditions who would benefit from participating in the CCIP.

Conditions for identifying enrollees for this purpose 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:

- The target chronic condition;
- The target population;
- How progress will be measured; and
- The data source (i.e., claims data, HEDIS, etc.).

Clinical Knowledge/Research

Reference the current clinical knowledge or research, which will be used as the basis for the CCIP quality indicators that are objective and clearly and unambiguously defined for purposes of performance assessments.

III. Target Population

Total Enrollment

Document the total number of enrollees.

Population Description

Document:

- 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
- The estimated number of enrollees and/or providers in the target population.

IV. Goal of CCIP

Target Goal

Because the performance assessments must use quality indicators that are objective, clearly and unambiguously defined, and based on current clinical knowledge or research, the target goal(s) must be a specific, quantifiable outcome measure linked to the planned interventions and appropriate for the targeted chronic condition. Effective CCIPs will include a description of the goal along with the specific number and/or percentage by which the MAO will measure improvement.

Baseline

Similarly, the initial baseline against which improvement is measured must be documented, objective, and clearly and unambiguously defined. Baselines should be set using a quantifiable numeric indicator that directly ties to the measure identified in the target goal section and measured using the MAO's data source(s).

National Standard (if applicable)

Use of national standards or benchmarks is recommended to demonstrate that the CCIP is using the required type(s) of performance assessments and quality indicators. The CCIP should 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.

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

The CCIP should identify the data sources used to measure the specific goal and include mechanisms for monitoring and evaluating participants. 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)

The intervention type(s) used should be identified, documented, and explain how they 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 (if applicable)

If using interventions, MAOs should describe each planned intervention(s) in a clear and logical way and indicate how the interventions will help to achieve the target goal and improve health outcomes.

VI. Measurement Methodology

Document the mechanisms for evaluating participant outcomes. MAOs should address methodology components, such as:

- How the data source(s) will be used;
- The target population specific to each aspect of the CCIP; and
- The quantifiable measurement of success.

Appendix B: CCIP Annual Update

MAOs must perform systematic and ongoing follow-up on the effect of the CCIP (422.152(c)(1)(iv)).

I. Do Section

Timeframe

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

Barriers Encountered (document all that apply)

MAOs should address barriers encountered during the project year, if any. 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
- Other

Mitigation Strategies (document all that apply)

MAOs should discuss how the barriers were addressed during the project year. 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 the anticipated goal(s) and/or outcomes were achieved. In addition, MAOs should document their analysis of the results/findings for any 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 participated in the CCIP, such as by receiving intervention(s).

Results and/or Percentage

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

- The CCIP results and/or percentage data;
- The numeric or percentage results comparing the target goal and baseline; and
- 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

MAOs should document 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. In performing systematic and ongoing follow-up on the effect of the CCIP, MAOs must document the following:

- A description of the actual or proposed changes; and
- Whether these changes have already been implemented or the plan for implementing these changes during the upcoming year.

Note: If there are NO changes from the initial CCIP Plan Section, or the CCIP is on track to achieve planned outcomes, then MAOs should document this in the Action Plan description.

Best Practices

As part of the systematic and ongoing follow-up on the effect of the CCIP, MAOs must document any identified best practices that have resulted from the findings and have worked well in producing positive outcomes. MAOs should include a detailed description of any best practices including:

- How the MAO identified these best practices(s);
- How these best practices have or will impact the CCIP and expected results;
- How the MAO will share the details of these best practices with others; and
- How the MAO will or may implement these best practices going forward.

Lessons Learned

As part of the systematic and ongoing follow-up on the effect of the CCIP, MAOs must document any identified lessons learned, either positive and/or negative. In doing so, MAOs should include a summary of how the lesson(s) learned during the reporting period influenced the results of the project, enrollees, providers, and/or other stakeholders.

Final CCIP Summary (3rd Annual Updates Only)

In the Final CCIP Summary section, the reported results must include a summary of the overall results, best practices, and lessons learned. This includes a clear identification and indication of the baseline compared to the target goal and discussion of any policies and best practices that will be carried forward.

Appendix C: 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

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

Evidence-Based Medicine

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

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 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.

Mitigation Strategy

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 (Chapter 16b - Medicare Managed Care Manual).

Target Population

A selected group of MA plan enrollees or providers that meet eligibility criteria for participation in a CCIP.

Appendix D: 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/Legac-Quality-Strategy.html

HPMS CCIP/QIP MA Quick Reference 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

https://dpap.lmi.org