

Janice Acar:

Good afternoon. Laura and I are here on behalf of CMS representing the MAQRO, which is the Medicare Advantage Quality Review Organization. Our colleague Jody Jobeck wasn't able to join us today, she had a family emergency but she's here in spirit. Laura and I decided that we're lucky to be the last presentation of the day because as we move to the welcome reception, our material will be fresh in your minds --

[laughter]

-- and your questions as well. We really do encourage you to come see us, especially if you have a monitoring audit scheduled for 2008.

So our presentation will provide you with a high-level overview of the requirements for Chronic Care Improvement Programs and Quality Improvement Projects. Since these are fairly new requirements and only a handful of MAOs have undergone these evaluations, we thought it would be helpful to describe the evaluation reporting and review process. And then following that, Laura will come up and discuss the specific requirements as well as some best practices that we have seen in the six months that we've been doing those reviews.

Finally, the last several slides of our presentation will give you some resources that you can use for the implementation and reporting of your CCIP and QIP projects. Again, I'd like to stress it's a very high-level overview, however, CMS and the MAQROs do intend to host a WebEx teleconference training session in the coming months.

The requirements for CCIP and QIP are delineated in the MA Audit Guide under Monitoring Elements QY08 and QY09. They're also in the Medicare Modernization Act, Title 2 under Subpart D, which is Quality Improvement. Then finally I think a reference that you've heard several times today, the Medicare Managed Care Manual, Chapter 5, which is quality assessment. So those are your three main resources regarding these requirements. These requirements apply to local coordinated care plans and local and regional PPOs. They do not apply to private fee-for-service plans, medical savings accounts, PACE plans, cost plans or the stand-alone PDPs. And the basic requirements that are stated here are that "MAOs must have in place a chronic care improvement program and successfully initiate and complete annual quality improvement projects." That's one each year.

As far as the review entity, if your MAO is being evaluated in conjunction with your regional office monitoring visit, then CMS's contractor, the MAQRO, which is us, will evaluate your CCIP and QIP using the CMS protocols that were developed for that purpose. However, if your MAO is deeming, through an accrediting organization, you will follow their processes and protocols. And for most cases that would be NCQA. However, AAAHC and URAC also are approved for Medicare deeming.

The MAQRO is comprised of three quality improvement organizations that would be Delmarva

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Foundation in Maryland, IPRO in New York and Lumetra in California. And the basic tasks that we were given were to develop the protocols and the guides for CCIP and QIP, which includes instructional guides, review tools and the review and scoring protocols. And in addition, to conduct reviews of the MAO, CCIP and QIP submissions and enter the results in the HPMS monitoring module. And well, we provide a complete review report to each MAO and the regional office. Additionally, we're asked to provide technical assistance and training regarding requirements, much like this presentation today and our upcoming WebEx.

The MAQRO project actually began in 2000 with the QAPI program. And at that time it was based on the QISMC requirements – if anyone remembers that – which was replaced by the MMA. An evaluation of the QAPI programs began in 2001. And then we took somewhat of a hiatus from late 2005 until late 2006, and then in early 2007 we began working again with CMS to update the protocols for QIP and to develop the protocols for the new CCIP requirements. Then again last year around June, it was, that we actually started to conduct the reviews.

This is a little bit of a comparison of the former process and the current process. Previously, from 2001 to 2005 only QAPI reported, there was no CCIP requirement. Reports were submitted electronically and annually via the HPMS QAPI module and if anybody used that -- we as the MAQRO were quite fond of it but I don't think many of you were -- and then the review and scoring were also completed via the HPMS QAPI module.

Now the process has changed to somewhat more of an accreditation review type of a process. Since 2007, now plans report both QIP and CCIP. Reports are submitted in conjunction with the monitoring visits which usually occur every three years, although that strategy has changed recently, and the reporting template is a Word document. Additionally, the review and scoring is done on a Word document and then the results are entered into the HPMS module under QY08 and QY09.

So how does this all work? CMS has developed the reporting templates for both QIP and CCIP, which are on the Web site and that link is at the end of the presentation. And those reporting formats must be used so that we get the information we need to evaluate your programs because these are a desk review only. We don't come on site. We get very limited opportunity to get clarification so it's very important that those templates are used so that we have the information we need to do the review.

Reporting must be done at the contract level, so that would be the R number or the H number level, but for large plans that are undergoing MRT or Multi-Region Team reviews, you can submit one report for each QIP and CCIP so long as they're identical in structure and then just submit addendums for each individual contract that describes the contract-specific data, any contract-specific interventions or other variations that occur at the local level. Additionally, you can submit attachments that describe your interventions or policies and procedures, your program descriptions, if you think these will help us to better understand your program because, again, we're just working off the paper reports.

So how it works is when you're due for your monitoring visit, the regional office will send out

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their introduction packet. And in that they will indicate which of the MAQROs has been assigned to do your project. In 2007 we rotated our assignments just by date so that we could have an even distribution of workload. However, for the coming year in 2008, we've each been assigned specific regions so that we'll work individually and consistently with the same regions. I guess another important point is that MAQROs will not be assigned to review MAOs in their own home state. Preferably the reports are submitted via e-mail electronically although hard copy is accepted, and you should submit the documentation to both the MAQRO and the regional office.

This is part of a flow chart that we had developed that describes the review process. And basically what it shows is that the MAO submits the CCIP and QIP documentation to the MAQRO and the regional office. Then the MAQRO conducts an initial review of the documentation that was submitted and we decide whether clarification is necessary. If we do need some clarification, what we would do is we'll send an e-mail with questions for clarification to the MAO and we'll send a copy to your regional office. And then your plan will have about two weeks to respond to those questions. In addition, I won't hesitate to mention that that's not the only contact we have with you. At any point during the process, once you're notified of your review, before you get the questions, after you get the questions, after you submit your responses, if you feel that you'd like to contact us, we are available and we do encourage you to contact us. I think Joanne from Passport [spelled phonetically] will attest to that for us.

After that point, when we get all the clarifications, we complete the review report and then we'll e-mail the full review reports to both you and the regional office. Then we'll enter the findings as met or not met for each of those elements in HPMS, QY08 and QY09. I would like to also mention that if a corrective action request is needed, we would inform the regional office before we sent the reports out.

So at this point, I'm going to turn this over to Laura and she's going to talk a little bit about the specific requirements as well as describe some of the best practices that we've seen.

Laura Stewart:

Thank you. I'm the last one of the afternoon here. I'm going to speak specifically about the Chronic Care Improvement Program and then the QI Projects. I'm going to focus mostly on areas within the report related to data sources or reporting of data, so it won't be covering every aspect of the reports.

So as a reminder, a general description of the CCIP is that "it should be designed to benefit enrollees with multiple or sufficiently severe chronic conditions. And ideally your program should integrate both high quality care management and disease management." And MA programs have a lot of flexibility in their design, and we certainly are seeing a lot of variation, but I'm going to share with you some of the reports that kind of best met the evaluation criteria.

This is some of the CCIP requirements as recorded in Chapter 5 and in the MMA. And I'm going to be touching on these as I go through the slides so basically the CCIP report template that CMS

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developed asks you to address all of these areas.

When MAQRO evaluates your CCIP reports, we first look to see are all areas of your report template addressed? As Janice mentioned, you do need to use the report template, even in the areas that are not necessarily required areas. They do give us information about your supporting elements for your CCIP and give us information about the processes that are used in your program. We look for evidence of systematic processes to determine eligibility, member progress and program outcomes. And the key here is that we look for systematic processes. We want to see evidence of ongoing processes that use your defined criteria for participation and that you identify your potentially eligible members and notify those members of their eligibility and offer them participation in the program and that you periodically evaluate the progress of the members in the program and you at least annually assess the effectiveness of your CCIP program.

When we're looking at your reports, we want to see that the program is actually being implemented; is it passed the committee stages where you're discussing the program? Certainly in the reports we saw in '07, there were various levels of implementation but the CCIP program requirements don't say that you have to have a certain membership before you implement the program. It basically needs to be started as your plan starts.

We look carefully at whether your interventions are likely to improve the coordination of care and health status of your participants. All of the other things you do, you know, trying to find your eligible members, defining your criteria, really are not going to do much benefit to the members unless your intervention strategy is strong. So although interventions were not explicitly addressed in Chapter 5 as a requirement, in the review we pay close attention to your reporting of your interventions. We look for whether standardized processes are integrated into your intervention strategies. So do you have algorithms and protocols and use evidence-based guidelines that are integrated within your program?

This slide talks about the criteria for CCIP participation, and under potential data sources gives you some examples of what we saw in the reports that came to us last year: Plans, have you been using a variety of sources including administrative claims and encounter data, laboratory data, pharmacy claims and various health risk assessment tools. The reports that best met our evaluation criteria were those reports that were very specific as far as their data sources, so they defined which ICD9 codes, medications, CPT codes were used. And that was important because that helps us to assess whether those sources are actually adequate for capturing the target population that you've told us you're trying to target.

The reports also describe frequency of data mining and timely analysis of claims and automated review of databases. Some of the new plans that we're just kind of getting rolling maybe tended to use their initial health risk assessments as their way of finding potentially eligible members. That's okay for a start, but you really need an ongoing process so that you are able to capture any changes in members' condition as time goes by. Then, risk stratification. A lot of plans use risk stratification either in their initial stages of identifying members or later in their intervention strategies. So you do need to explain your use of risk stratification.

The CCIP data reporting expectations. Currently there's actually the data that you actually have to report is mostly related to the relevance of your CCIP, to your MA population, and data related to your eligibility and participation rates. In the template that was revised last year, and that will be on the CMS Web site for reporting this year, actually has added a little table so that it asks you specifically to list the prevalence in your MA population for each of the diseases that you're targeting. The rates should be listed by your CMS contract, and you need to give just a very brief rationale for why you're targeting the particular disease conditions in your program, either the impact, the morbidity or disability that the disease might have, you opportunities to improve or that you're just going to reach a lot of members or any combination of those types of rationale.

Eligibility and participation. I've noted up here that needs to be reported by disease at the contract level. But also, if you're risk stratifying, we need to know how many members are participating in your low risk versus high risk because when we assess the effectiveness of your interventions, it really does have an impact on how many and in which risk stratification.

Monitoring progress of individual CCIP participants. This area of the template's been a little bit confusing for plans reporting in 2007. It is asking about how you assess your individual participants. These aren't asking, in this section, for population measures. Data sources that plans have been reporting are lots of telephone assessments that are assessing clinical parameters and progress toward patient self-management goals. Some plans are using telehealth monitoring and many plans are doing surveillance of claims, pharmacy and other lab data.

And the reports that best met evaluation criteria described their written policies and protocols or at least gave evidence that there were protocols in place to determine appropriate levels of monitoring. So what didn't vary across whatever RN or care coordinator was contacting members but there was some actual protocol in place for the staff. And there are processes to address various risk stratifications and sufficient frequency of follow-up to detect and act on any changes in health status in a timely manner.

And then another section of the report and another requirement for CCIP is to do quantitative measures of improvement. This is where you want to report your population-based measures that are used to evaluate overall program effectiveness. They can be a clinical outcome measure, satisfaction or cost of outcomes. The measures are just defined in your report for us, you're not actually reporting the data at this point in time, but the definitions do have to be valid definitions and they need to be assessed annually. So you really need to tell us what is it that your QI program is looking at, at least on an annual basis to make determinations on whether your CCIP program is effective or whether modifications need to be made.

Reports that best met the evaluation criteria defined measures relevant to each targeted disease and specified appropriate denominators, numerator inclusion and exclusion criteria.

I'm going to move on to Quality Improvement Projects, and I'm going to go through this really quickly. People tend to be more familiar with the QIP projects since the requirements aren't new

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compared to how the CCIP program is. But one thing that was confusing for the new plans is the idea of initiating one new project annually. In the Medicare Managed Care Manual, Chapter 5, you'll notice that in general the QI projects are expected to last about three years, because most people use a one-year measurement time frame and you need to have a baseline and two remeasurement periods. So from some new plans that were submitted, QIPs were reporting projects were maybe six months long or less than a year and thinking that was done but, in fact, that's not. You really have to stretch that project out so the system-level interventions can really make an impact throughout the system.

The QIP topic needs to be data-driven. You really need to look at your HOS data, your HEDIS data, your CAPS data or whatever other data you want to use and determine a topic where you have potential for improvement. In the reports, you do need to describe to us how you determined that the topic was relevant to your population, not just to Medicare beneficiaries in general, but specifically to your MA population and how the topic was prioritized.

I'm not going to spend a lot of time on QI indicators. A lot of plans are using HEDIS indicators for their QI projects. When they use that, they can just tell us which HEDIS year and specifications they're using. I just want to do a little warning that for the new plans that try to do plan-defined indicators had some challenges in writing their own kind of valid indicators. So if you're trying to find QI indicators, refer to our indicators or your state QIO. We also in our MAQRO guide book we also have information on that, so to make sure you're starting on your right track with your project.

Data sources are also reported to us, where you're getting data. And when you report to us, if you're using audited HEDIS data or CAPS data or HOS data, you do not need to go into detail your methodology, but if it's not that type of data, you do need to explain to us, in fair amount of detail, your methodology so we can assess whether the data is valid and reliable and comparable over time.

In interventions, we want to see interventions that are system-level, usual multiple interventions. And in this example, just to point out if you read that slide is that you can analyze your data down to the provider level and do an intervention that is focused on providers who might most need information to improve a particular quality indicator. That's just to point out that the data is not only driving your selection process and your re-measurement and everything, but in your intervention planning, you also should be paying careful attention to your data analysis.

This is a resource on Chapter 5 and the templates on the CMS Web site and the MAQRO contacts. And also we work closely with our CMS government task leader, April Grayson, and we have weekly conferences with her and discuss plans, reports and all so we have close contact with CMS ongoing. And we will be available to answer any questions in the reception.

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