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September 6, 2011

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS–10209/ OMB# 0938–1023
Room C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244–1850

Re: **CMS–10209 (OMB#: 0938–1023)**

Dear Sir or Madam:

I am writing on behalf of America's Health Insurance Plans (AHIP) in response to the notice published under the Paperwork Reduction Act (PRA) in the Federal Register (76 FR 40370) on July 8, 2011, by the Centers for Medicare & Medicaid Services (CMS) concerning the "Medicare Advantage Chronic Care Improvement Program and Quality Improvement Project Reporting Tools." AHIP is the national trade association representing the health insurance industry. Our member companies provide health care coverage to more than 200 million Americans. The draft reporting tools are of significant interest to AHIP's member organizations, many of which participate in the Medicare Advantage (MA) program. Our comments appear below.

GENERAL COMMENTS

- **Instructions.** The draft QIP and CCIP Reporting Tools do not include draft instructions indicating how Medicare Advantage organizations (MAOs) are to complete the reporting tools. Without this information, the agency's expectations for a number of the items are unclear as noted in our more detailed comments, and it is not possible to comment fully on issues raised by the proposed reporting tools. When the draft tools are issued for further comment under the Paperwork Reduction Act, AHIP recommends that CMS issue the related draft instructions to provide a comprehensive understanding of the initiative that will permit more thorough comments.

- **Scoring Methodology.** The draft QIP and CCIP Reporting Tools do not include draft criteria and methodology for scoring and evaluating MA organization submissions. Insight on this topic is important to MAO efforts to ensure that they are complying with CMS expectations for designing and implementing their projects and programs and to permit MAOs to maintain or achieve high performance if CMS continues to move

forward with plans to incorporate QIPs and CCIPs into the Star Ratings system. AHIP urges CMS to make available the detailed criteria CMS will utilize to evaluate and score MAO QIP and CCIP submissions.

- **Submission of Ongoing QIPs and CCIPs.** An August 18, 2011 CMS memorandum stated that the first QIP and CCIP submissions utilizing the new tools would be due to CMS in February, 2012. It appears that this deadline will necessitate reporting on projects and programs initiated prior to issuance of the draft tools. MAOs will not have had an opportunity to incorporate into their ongoing projects any changes that may be warranted based upon CMS' evaluation of QIPs and CCIPs submitted last year nor to be responsive to CMS priorities that may be reflected in the agency's evaluation and scoring criteria. AHIP recommends that CMS address in the instructions accompanying the tool how CMS will take into consideration in its evaluation and scoring of ongoing projects the lack of advance notice of the agency's new approach, including, as noted above, details of evaluation and scoring criteria that CMS will apply.

- **Coordination with SNP Requirements.**
  + ***QIP and CCIP Submission Requirements and Timeline.*** The August 18, 2011 CMS memorandum that addresses QIP and CCIP submissions indicates that there will be two annual reporting deadlines which will occur in February and April. However, SNP quality improvement staff responsible for QIPs and CCIPs already must meet other CMS February reporting deadlines. The annual deadline for SNPs to report Structure & Process (S&P) measures falls at the end of February when there also are specific elements of the SNP Proposal that must be submitted in coordination with the February application deadline. The S&P Measures include requirements for QIPs and for some existing SNPs, the information submitted through the application process includes Model of Care. Convergence of these deadlines could produce serious resource challenges for SNPs and raises questions about how CMS will coordinate these requirements. Potential overlap among the requirements heightens these concerns.
    -- ***CMS-Required QIP on Plan All Cause Readmissions.*** The August 18 CMS memorandum announced that the agency is requiring all MA organizations to develop and implement a QIP that addresses all cause readmissions for each of their plans for the 2012 – 2013 submission cycle. SNPs are already required to implement three QIPs to satisfy requirements under the SNP S&P measures. Because these projects cannot include issues that involve only reducing utilization, such as decreasing the rate of hospitalizations, SNPs could need to pursue a fourth required project to address all-cause readmissions.

We recommend that as CMS continues development of the QIP and CCIP Reporting Tools and related instructions and guidance, the agency evaluate the interaction of these requirements with ongoing quality-related SNP requirements. We also recommend that CMS take steps to better align SNP and generally applicable MA requirements by coordinating the timing and content of required submissions, including coordinating the number of projects SNPs may be required to implement under the SNP S&P Measures. We recommend that CMS revise the guidance for QIP and CCIP reporting and/or the SNP-specific requirements to strike a workable balance. We also recommend that CMS issue guidance that explains the relationship between the QIP and CCIP Reporting Tools and SNP-specific requirements.

+ ***CMS-Designated CCIP Area of Focus.*** The August 18 CMS memorandum referenced above also announced that the agency is requiring all MA organizations to develop and implement a CCIP focusing on decreasing cardiovascular disease for the 2012 – 2013 submission cycle. This policy also raises questions about coordination with SNP requirements. SNPs are accountable for tailoring their quality improvement activities to the specific populations they serve and particularly in the case of Chronic Care SNPs (C-SNPs), priorities that are selected for MA enrollees as a whole may not be the most meaningful topics for SNP enrollees. For example, CMS' focus for 2012 on cardiovascular disease may not be as appropriate for C-SNPs focused on individuals with ESRD. In addition, SNPs are already dedicating substantial resources to quality-related initiatives, and it could hinder their efforts to comply with SNP-specific requirements if they face resource challenges as a result of pursuing projects that are of less importance to their enrollees. AHIP recommends that CMS revise the requirement that all MA organizations must implement a CCIP with a CMS-designated focus by creating an exception for SNPs in recognition of their responsibilities to focus CCIPs on their target populations.

- **Number of Contracts per Document.** We understand that MAOs may establish QIPs that are implemented across many or all contracts. In these cases, separate completion of the tool for each contract could necessitate entry of the same information multiple times and redundant submissions to CMS. AHIP recommends that CMS provide a streamlined process for reporting of QIP information applicable to multiple contracts, for example, by permitting inclusion in a single submission of information for multiple contracts or another approach designed to achieve administrative efficiency for MAOs as well as CMS and avoid repetitive reporting.

- **Supporting Statement; Item 12. Burden Estimate (Hours and Wages).** CMS estimates it will take 5 hours for a respondent to complete the CCIP reporting tool and 5 hours to complete the QI project reporting tool. While electronic submission can be expected to improve the efficiency of submissions, significant preparation will be required to collect and enter the required information. Further CMS estimates that the agency will require 6 hours for both contractor reviews and Regional Office account manager reviews for each submission. We believe it is typically significantly more time-consuming to prepare a submission than to perform the review. AHIP recommends that CMS reevaluate the burden estimate to more accurately reflect the time it will take organizations to collect and enter the information required by the tools.

SPECIFIC COMMENTS

QIP Reporting Tool

A. Medicare Advantage Organization (MAO) Information (page 1)

+ This section includes a field for the MAO to provide an identification number. It is not clear what identification number plans should use to complete this field. AHIP recommends that CMS clarify how the field for the identification number must be populated or delete this field.

+ This section also includes a field for MAOs to indicate whether the project cycle is baseline, years 1, 2, and 3, or other. It is not clear how CMS would define the baseline year in comparison to year 1 and how these designations would relate to the "Plan", "Do", "Study", and "Act" phases of QIPs. To promote consistent understanding by MAOs of the information they must provide, AHIP recommends that CMS provide instructions for the tool that explain the stages in the project cycle and explain how they relate to the QIP Plan/Do/Study/Act phases reflected in the tool.

B. Background (page 1)

+ This section includes a field for MAOs to fill in the "Domain (if applicable)." It is not clear if the tool requires a domain designation from HEDIS, CMS star ratings, or other domain system. AHIP recommends that CMS provide instructions for the tool that indicate the source of the domains that could be used to complete this section.

PLAN

E. Basis of Selection (page 3)

+ This section includes a field for MAOs to indicate the impact on members in the categories of health outcomes and member satisfaction. MAOs may develop QIPs that address issues other than these two options. AHIP recommends that CMS provide an option for MAOs to choose "Other" and fill-in the category that best characterizes the type of member impact under the QIP.

F. Budget and Resources (page 3)

+ This section requires MAOs to provide information in the following categories: "Financial," "Resources," and "Priority Assessed." The relevance of these categories to CMS assessment of a QIP is not clear, and it is also unclear how such information would be evaluated by CMS and scored. Further, under the "Priority Assessed" category, the descriptions of High, Medium, and Low priority projects are not consistent with the manner in which MAOs would characterize QIPs. For example, a "high" priority is described as "Imminent danger or potential harm study, must be implemented within the next 3 months." "Imminent danger and potential harm" are generally understood to necessitate quick action that must be completed much more quickly than within 3 months. AHIP recommends that CMS eliminate this section of the reporting tool or if it is retained, provide instructions to explain the purpose of collecting the information and how it will be used in evaluating QIPs, including criteria for scoring. If this section is retained, we recommend that CMS reconsider the descriptions of the priority options included in the draft and engage in discussions with MAOs to develop descriptions more consistent with descriptions that are currently utilized.

G. Prior Focus (page 3)

+ This section requires MAOs to provide information in four categories about previous attempts to address the problem identified for the QIP. It is not clear what level of detail CMS expects MAOs to provide for each category. For example, it is unclear whether MAOs should provide in each row a high level summary for each year or populate the rows with information related to a single intervention. Also, in the case of previous QIPs, it is unclear whether the "Priority Assessed" should relate to the QIP or each intervention. AHIP recommends that CMS provide instructions that describe the level of detail MAOs should include in completing this section of the tool and include examples to illustrate how the tool should be completed (e.g., whether the priority assessment relates to the QIP or interventions).

H. Project Goal and Benchmark

+ **H.1: Target Goal and Benchmark (page 4).** In section H.1., the reporting tool requires MAOs to provide a target goal and benchmark and in the benchmark field provides three choices: "Baseline", "Internal", and "External". It is unclear what each of these choices means. AHIP recommends that CMS provide instructions that explain the meaning of the terms "Baseline", "Internal", and "External" and provide examples of how benchmarks associated with each category would be developed.

+ **H.2: Risk Assessment (page 4).** In section H.2., the reporting tool includes a field labeled "Intervention", and in section H.1. the tool includes a field labeled "Planned Intervention". It is not clear how MAOs are expected to distinguish between these fields. This section also includes fields for "Anticipated Barrier" and "Mitigation Plan." In some cases an MAO may not anticipate barriers for all interventions or have associated mitigation plans. It is not clear whether all interventions should be listed under H.2. or only those associated with an anticipated barrier and mitigation plan. AHIP recommends that CMS provide detailed instructions for completing this section that include an explanation of the distinction between the interventions referenced in H.1. and H.2. and whether all interventions should be listed in H.2. or only those for which all fields could be completed.

I. Plan Project Approval (page 4)

+ This section includes a field for "Name of Individual" and indicates it should be completed by the "responsible person." However, the purpose of the section is unclear. For example, the "responsible person" who may be the appropriate contact to respond to questions about information entered into the tool could differ from the individual with senior management responsibility for the QIP. AHIP recommends that CMS provide instructions that explain the purpose of the item and clarify the responsibilities of the individual who should be named in this section. We have included a similar comment below concerning the comparable section of the CCIP Reporting Tool and recommend that CMS consider making these sections of both tools identical.

J. CMS Regional Office Approval (page 4)

+ This section includes fields to indicate whether the CMS Regional Office (RO) approved the QIP, and an August 18, 2011 memorandum indicates RO staff will review and approve the April 2012 submissions that address the "Plan" phase of new QIPs. CMS has not yet provided further information about this new approval process for QIPs. AHIP recommends that CMS issue guidance that includes the

timeline for the RO review process, criteria for review and other relevant details. We have included a similar comment below concerning the comparable section of the CCIP Reporting Tool. We note that this section of the CCIP tool includes a notation that, "The above information will remain in the system for reporting in subsequent years." We recommend that this language be added to section J. of the QIP tool.

DO

K. Project Implementation Review and Revisions (page 5)

+ Section K.2. requires submission of information about risk mitigation, and it is not clear how CMS defines this term. In addition, the section includes a field for "Measurement Methodology" that is not clearly distinguished from the "Methodology" field in section H.1. AHIP recommends that CMS provide instructions for MAOs that include a definition of "Risk Mitigation" and distinguish the Measurement Methodology" field in section K.2. from the "Methodology" field in section H.1.

STUDY

L. Results (page 6)

+ This section includes an "Intervention" field that will be auto-populated from the Plan section of the tool. However, the Plan section permits MAOs to list multiple interventions. Consequently, it is unclear whether this section is intended to require summary data for the QIP or data on each intervention. In addition, the "Project Cycle/Year" column includes rows for a Baseline and three Re-measurement periods. It is not clear whether CMS intends that the project cycle should be a year in every case. AHIP recommends that CMS provide instructions for MAOs that clarify the information that MAOs must provide in this section.

ACT

M. Summary of Findings or Study Conclusions

N. Next Steps

O. Action Plan Description (page 7)

+ This section requires narrative responses about the study findings and conclusions, best practices, and lessons learned. In contrast, the reporting form MAOs were required to submit in 2010 required descriptions of study findings and conclusions but descriptions of best practices and lessons learned were optional. Completion of the additional narrative would substantially increase the time necessary to complete the tool in comparison to the form. In addition, depending upon the level of detail CMS requires, the descriptions in section "O. Action Plan Description" and section "P. Root Cause Analysis Description" could

require a significant investment of time to complete. To permit MAOs to allocate time and resources appropriately, CMS should provide guidance concerning the amount of detail required under each of these sections.

In addition, it appears that it would be most appropriate for MAOs to complete sections M., N., and O. at the conclusion of QIPs rather than annually to capture findings based upon full experience under the project and identify next steps. It is unclear based upon review of the tool whether this is CMS' intent.

AHIP recommends that CMS provide instructions for MAOs that clarify the level of detail that CMS expects MAOs to include in sections M., N., and O. of the tool. We also recommend that CMS initially provide that the best practices and lessons learned sections will be optional in light of the investment of time likely to be required for MAOs to initially complete the tool. As MAOs gain experience with the tool, CMS could reconsider whether these elements should be required. We also recommend that the instructions clarify that sections M., N., and O. will be required at the end of the QIP and not annually.

P. Root Cause Analysis Description (page 7)

+ Section "P. Root Cause Analysis Description" is the last section in the QIP Reporting Tool and follows Next Steps and Action Plan Description. We understand that typically MAOs would undertake root cause analysis prior to determining next steps and developing an action plan. AHIP recommends that CMS move section "P. Root Cause Analysis Description" to be placed before section "N. Next Steps" to more accurately reflect the flow of analysis that MAOs perform for QIPs.

CCIP Reporting Tool

Medicare Advantage Organization (MAO) Information

+ **CCIP Initial Plan Approval Submission (page 1).** Under the "No – Subsequent Year Report #," the reporting tool provides choices for years 1 – 5. It is not clear whether CMS intends for CCIPs to be implemented for a five year period. The Results table in the Study section of the tool is also structured to accommodate 5 year CCIPs. We understand that MAOs conduct CCIPs that vary in length, and it is unclear whether and how CMS intends that the reporting tool would accommodate such programs. AHIP recommends that CMS provide instructions for MAOs that include a clarification that CCIPs may vary in length and explains how MAOs would complete the tool for CCIPs with a duration shorter or longer than five years.

PLAN

A. Basis for Selection (page 2).

+ This section requires MAOs to, "Describe the basis for selecting the specific chronic condition for the CCIP with anticipated or desired measurable outcomes." We understand that in prior years MAOs have been permitted to implement CCIPs that manage multiple chronic conditions and co-morbidities. The reporting tool does not appear to permit CCIPs to include more than one disease state. AHIP recommends that CMS revise section A. to permit continued reporting on CCIPs that address multiple chronic conditions and co-morbidities.

B. Program Design

+ **B1b. Method of identifying members: (drop down box) (page 2).** The drop down box in this section appears to permit MAOs to indicate only one method for identifying members in the population rather than selecting all that apply. We understand that MAOs may use multiple methods for identifying members to participate in the CCIP. AHIP recommends that CMS revise the reporting tool as needed to permit MAOs to select all methods that apply for identifying members for CCIPs and provide corresponding instructions.

+ **B2. Evidence Based Medicine (page 3).** This section asks the MAO to, "Provide current clinical guidelines and evidence-based treatment modalities, standards of care, evidence-based best practices, etc." It is not clear what level of detail MAOs are expected to provide when completing this section of the tool. For example, MAOs could include a list of the practice guidelines and their source, provide a summary describing the guidelines selected, or provide a copy of the complete guidelines document. AHIP recommends that CMS provide instructions to clarify the expectations for this section including the sources of information and level of detail that MAOs must provide.

+ **B3. Practice Model (page 3).** This section requires the MAO to, "Describe the model, e.g., integration, collaboration, community resources, communication among team members including provider, patient, and CCIP team members." It is not clear what level of detail CMS expects MAOs to include in this section. AHIP recommends that CMS provide instructions to clarify the agency's expectations and provide examples of the information that MAOs should include in this section.

+ **B4. Patient Self Management Education (page 3).** This section requires the MAO to "Describe the method of education and the topics covered" and complete a table that includes rows labeled training, support, monitoring, follow-up, and other. We are concerned that the categories reflected in the rows may not align with the nature of plan education activities. For example, we understand that MAOs may use a continual patient education approach that cannot readily be divided into the specified categories. A more flexible approach is needed to accommodate the range of activities MAOs are implementing. AHIP recommends that CMS revise the tool to be more compatible with the varied structure of Patient Self-Management Education activities implemented by MAOs. We also recommend that CMS provide instructions for MAOs explaining how to complete this portion of the tool and include examples.

+ **B5. Outcome Measures and Interventions.**
  -- **1. Goal/Benchmark (page 4).** The tool offers three choices for providing information about the benchmark, "Baseline", "Internal," and "External." It is unclear what each of these choices means. AHIP recommends that CMS provide instructions that explain the meaning of the terms "Baseline", "Internal", and "External" and provide examples of how benchmarks associated with each category would be developed.

C. Budget and Resources (page 5)

+ This section requires MAOs to "State the amount budgeted and the planned resources, such as FTEs, technology and information systems, etc., allocated to implement the CCIP." The relevance of these categories to CMS assessment of a CCIP is not clear, and it is also unclear how such information would be evaluated by CMS and scored. AHIP recommends that CMS eliminate this section of the reporting tool or if it is retained, provide instructions to explain the purpose of collecting the information and how it will be used in evaluating QIPs, including criteria for scoring.

D. MAO CCIP Responsibility (page 5)

+ This section requires MAOs to report the name of an individual with "MAO CCIP Responsibility." However, the purpose of the section is unclear. For example, the individual with "MAO CCIP Responsibility" who may be the appropriate contact to respond to questions about information entered into the tool could differ from the individual with senior management responsibility for the CCIP. AHIP recommends that CMS provide instructions that explain the purpose of the item and clarify the responsibilities of the individual who should be named in this section. We have included a similar comment above concerning the comparable

section of the QIP Reporting Tool and recommend that CMS consider making these sections of both tools identical.

E. CMS Regional Office Approval (page 5)

+ This section includes fields to indicate whether the CMS Regional Office (RO) approved the CCIP, and an August 18, 2011 memorandum indicates RO staff will review and approve the April 2012 submissions that address the "Plan" phase of new CCIPs. CMS has not yet provided further information about this new approval process for CCIPs. AHIP recommends that CMS issue guidance that includes the timeline for the RO review process, criteria for review, and other relevant details. We have included a similar comment above concerning the comparable section of the QIP Reporting Tool.

DO

Program Implementation, Review and Revision (page 6)

+ Throughout the "Do" section of the reporting tool, MAOs are required to describe results or findings for each intervention, barriers, risk mitigation, and the anticipated impact on the goal or benchmark. It is our understanding that MAOs may have relevant reports (e.g., disease management program reports) that could provide information required by this section of the tool. However, it is not clear whether the tool would permit MAOs to embed such documents in the fields provided. AHIP recommends that CMS design the tool to permit relevant documents to be embedded in the fields in this section and provide instructions for MAOs that explain they may submit required information through use of such materials.

+ **4. Risk Mitigation (page 6).** This section requires MAOs to "Describe the actions taken to mitigate the risk." However, it is not clear how CMS defines "risk." AHIP recommends that CMS provide instructions for MAOs that include a definition of "Risk Mitigation."

STUDY

Results

+ **1. Goal/Benchmark (page 7).** This section includes an initial period and four re-measurement periods. It is not clear how MAOs are expected to report information for ongoing CCIPs that have existed for a number of years, for example, whether this would entail reporting historical data. AHIP recommends that CMS provide instructions for MAOs that clarify the information that MAOs must provide in this section.

We have appreciated the opportunity to comment. Please contact me if additional information would be helpful or if you have questions about the issues we have raised. I can be reached at (202) 778-3209 or cschaller@ahip.org.

Sincerely,

Candace Schaller
Senior Vice President, Federal Programs

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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September 6, 2011

Ms. Michelle Shortt, Director
The Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Divisions of Regulations Development
Attention: Document Identifier/OMB Control Number 0938-1023
Form Number CMS-10209

Filed at www.regulations.gov

Dear Ms. Shortt:

The Blue Cross and Blue Shield Association is pleased to submit the following comments on the Information Collection related to "Medicare Advantage Chronic Care Improvement Project Reporting Tools" as issued in the Federal Register on July 8, 2011 (Fed. Reg.40371).

Our comments are as follows:

1. **Request for Instructional Guides.** We appreciate that CMS is including general completion instructions for the proposed CCIP and QIP templates, and support the overall strategy of developing training and technical assistance prior to implementation.

   To ensure consistency in implementation among plans, we recommend that CMS provide ***Instructional Guides*** similar to the ones previously supplied (see attached). The Instructional Guides should contain detailed guidance that can be referenced outside of trainings and during consultations with staff from CMS Central and Regional Offices. It is essential that plans have such a single-source reference containing the guidance required for them to remain compliant, efficient, productive and timely in the implementation of QIPs and CCIPs.

   Among others items, the ***Instructional Guide*** should address the following:

   - In the **QIP TEMPLATE, Section O & P,** CMS is requiring new areas, such as Action Plan Analysis and Root Cause Analysis. Without having a detailed explanation of what is required of plans for these new sections, it could take plans a considerable amount time to complete the QIP template. For this reason, we support and recommend clear and timely dissemination of the details for completing the QIP template, including the new required sections.
   - In the **CCIP TEMPLATE, under "Plan" section B2,** CMS is proposing that plans "*provide current clinical practice guidelines, and evidence-based treatment*

modalities, standards of care, evidence-based best practices, etc." While we are prepared to list the applicable ***Evidence Based Medicine*** guidelines followed by the CCIP program, it would be helpful if CMS clarified whether the agency's expectation is for plans to also identify and list the Nationally Recognized Clinical Practice Guidelines, standards of care, etc., that are followed by the plan.

In order to maximize its usefulness, we request and recommend that the new ***Instructional Guides*** be provided well in advance of the time of the first training opportunity, and in no case later than the time of that training.


QIP_instructions.pdf


CCIP_guide.pdf

2. **Modifications to Submission Cycle.** In CMS' proposal, there are two submission periods under the new process, with the first submission anticipated in February 2012 and the second in April 2012. CMS states its expectation to continue these submission cycles annually and will provide more detailed guidance and timelines in the fall of 2011. The February 2012 submission will include all sections of the PDSA templates and will use data collected during 2011. We generally support CMS' proposal to use a **defined submission cycle,** but offer the following comments and recommended modifications to the cycle:

    - We support the February 2012 submission date, as it allows for use of the data collected in 2011.
    - We recommend CMS change the April 2012 CCIP-QIP submission cycle to September 1, 2012, in order to better align with the availability of current HEDIS data. MAOs select topics based on data typically pulled from validated HEDIS, completed CAHPS, HOS information and/ or completed claims run out. Because HEDIS is a primary source of data and is not available until mid-June, the second cycle should be extended to September to ensure that the most current data available is being used.
    - As part of the twice annual submission cycle, it would be helpful if plans were to receive feedback from CMS to verify that the QIPs and CCIPs are meeting CMS' expectations. For this reason, we request that CMS provide general feedback and pass/fail feedback on the QIPs and CCIPs submitted.
    - With respect to new plans, CMS previously made it clear that QIP and CCIP topic selections and preparations were not expected until the second year, when plans had collected enough data to adequately inform their submissions. It is unclear whether this remains true for the new process. We recommend that CMS maintain its previous direction to delay QIP and CCIP topic preparations until the second year.

3. **Termination of Existing QIPs.** Plans are currently required to maintain a QIP for a minimum of three years and longer if there is no evidence of improvement. In the revised templates, CMS is proposing significant modifications to the data and processes required for compliance with these programs. Therefore, we strongly recommend that the current QIPs be terminated, and new QIPs initiated, to eliminate the confusion and administrative burden of maintaining programs under two very different sets of requirements. We note that there are other mechanisms currently in place for plans to continue monitoring QI opportunities, including the QIPs that would be terminated.

4. **Testing and Design of HPMS Module.** CMS notes it is in the process of developing a module in the Health Plan Management System (HPMS) that is intended to decrease the burden on plans associated with preparing and submitting the CCIPs and QIPs. We appreciate this development and recommend that CMS offer a beta testing period and involve plans in finalization of this new module. Such a collaborative effort will be particularly important to make sure that practical implementation issues are considered and addressed, such as the following:

    - In some cases, a MAO may have multiple plans with QIP topics that apply to all plans. For this reason, we recommend the HPMS CCIP-QIP submission module be developed to accept a single CCIP-QIP report for multiple plans, similar to the format that CMS uses for other modules such as the Medication Therapy Management submission module or the process applicable for offshore contractor attestations. This would be a more efficient process consistent with the Paperwork Reduction Act and would reduce the substantial resource and time burdens MAOs would otherwise experience if required to enter each QIP by plan (even when the QIP topic /interventions are the same).
    - The proposed CCIP and QIP templates do not reference an option for attachments. Because MAOs frequently prepare data on interventions, outcomes, and improvement in a manner that best reflects the CCIP or QIP plans, we recommend the HPMS module be developed to accept attachments. At a minimum, we recommend allowing plans to submit attachments during the review and approval submission to the Regional Office.
    - Most MAOs employ several levels of internal review as they prepare the CCIP and QIP submissions. In CMS' proposal, it is unclear if the new HPMS module will allow for a multi-user interface that will ensure this type of internal collaboration can continue to occur. We recommend the HPMS module be developed to allow for review and editing by multiple internal parties prior to final submission for approval by CMS.

5. **Clarification of Submission Process.** CMS is requiring regional office (RO) approval as a new part of the CCIP and QIP submission process. We recommend additional clarification on how this process will work and what the consequences and opportunities for re-submission are in the case of a rejection by the RO. For example, we recommend that the

RO provide an approval or rejection within 60 days. If the program is rejected, we recommend the MAO be allowed a 90-day period to correct and re-submit their program.

6. **Reporting of Budget Information.** CMS is proposing that the new CCIP-QIP submission process include details related to budget and resources. Plans currently provide administrative costs and resources as part of the product filing in June of each year for CMS approval, and these costs include the overhead estimated to support Quality and Chronic Care programs for Medicare Advantage. In addition, MAOs with multiple plans typically apply enterprise support for interventions that cross multiple plans or selected topics. For these reasons, we recommend against a separate report of costs and resources on the QIP and CCIP templates because the provision of costs/resource breakdowns by plan or topic will be burdensome and may not be very accurate or meaningful.

7. **Modifications to CCIP Template.** CMS' proposed CCIP template requests new data not previously provided by plans. With respect to these new sections, we note the following:

    - Under the "Plan" section of the CCIP template, CMS is proposing MAOs complete several data points for the ***specific condition***. We recommend clarification that the "***specific condition***" can be more than one condition based on prevalence and priority. In addition to this clarification, we recommend that CMS allow for one CCIP report even when the MAO has a CCIP program that addresses multiple conditions. Many CCIPs appropriately address the challenges inherent of co-morbid conditions in the elderly. A holistic approach to managing the primary condition and related co-morbidities should be reported as such when the CCIP program is designed to focus on more than one specific condition.
    - Under "Plan" section B4, CMS is proposing that plans report "*Patient Self Management".* Because most patient education is continual and builds off previous discussions by either expanding or reviewing the topics, it will be challenging for plans to distinguish between the various areas of care. For this reason, we recommend that CMS remove the categorization of the Patient Self Management methods (training, support, monitoring, follow-up, and other) as it adds limited value and increases the reporting time.

Thank you for the opportunity to provide comments on this collection. If you have any questions, please contact my office at 202.626.8651 or by email at Jane.Galvin@bcbsa.com.

Sincerely yours,

Jane Galvin
Managing Director
Regulatory Affairs

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tn

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General Comment

BlueCross BlueShield of Tennessee, Plan H5884 and H4979 would like to submit comments regarding Revised MA Quality Improvement Project (QIP) and Chronic Care Improvement Program (CCIP) Reporting Tools.

Our biggest concern/comments are:

1. How can CMS use our 2010 QIP and CCIP submissions to "develop a baseline of MAO performance" when no formal training was given and no reference materials were provided to complete the prior tool(s)? If CMS is changing the tool, the baseline performance should be established on the new tool.

2. The tools, although helpful, are not consistent with the scoring methodology presented in the recently updated Chapter 5 of the Medicare Managed Care Manual. For instance, the evaluation of the QIP and CCIP as described in this chapter indicates there are 5 and 7, respectively, compliance indicators. It would be of extreme value to the health plans to be able to identify on the new tool, which areas correspond with each of the compliance indicators. This is of utmost importance since the QIP and CCIP scores are being considered as new Star measures in 2013.

Feel free to contact me at 423-535-6235 or email at Deborah_Rowe@bcbst.com for any additional questions.

Thank you,

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CCIP Template:
Over all, The CCIP tool was easier to follow and there aren't as many questions regarding how to complete it or what CMS is looking for in completing the template.

1) It is unclear whether plans have to complete a separate template for each condition being managed through the CCIP program or whether we can we submit one template addressing/explaining all disease states being managed. Please clarify.

2) It is unclear how we use this template if CMS approves our CCIP that was submitted in Aug 2010. It appears that this template is set up to be used when an initial program is being designed and managed. Please clarify.

3) Section C Budget and Resources:
   - There is no explanation in the supporting statement or summary of changes regarding this new section. Please explain the purpose of this information. It appears that budgets and/or resources may affect the grading of the program. We do not feel this information should be used in this manner.
   - More detail is needed regarding how CMS wants this information documented
     - Definition of initial plan year and so forth. Is it the initial planning year of the CCIP in general or when a certain disease category began being monitored in the CCIP?
   - With regard to FTEs and their time/salaries spent with the CCIP it is difficult to determine as these FTEs may have other responsibilities that are not part of managing or working with the CCIP program.

QIP Template:

Overall, CMS will need to provide an instruction manual with definitions and examples of how the template is to be completed. In our reading of Chapter 5 of the Managed Care Manual, there doesn't appear to be a way to compare how the plans would be graded on their program and how the template would show that we were meeting specific grading components. We suggest a map or crosswalk on how the template will be reviewed in correspondence to the grading outlined in Chapter 5.

Here are specific areas in need of clarification:

1) Section B Background:
   - Please define what Domain means

2) Section D Based on Model of Care- H2425 is a SNP
   - More explanation is needed regarding what is being required in this section.
     - Should this be completed if a QIP is focusing on a portion of the MOC to improve or should the MOC submitted?

3) Section E Basis of Selection
   - More explanation/instruction is needed regarding the expectations of E1, E2 and E3.

4) Section F Budget and Resources
   - There is no explanation in the supporting statement or summary of changes regarding this new section. Please explain the purpose of this information. It appears that budgets and/or resources may affect the grading of the program. We do not feel this information should be used in this manner.
   - With regard to FTEs and their time/salaries spent with the QIP it is harder to determine as these FTEs may have other responsibilities that are not part of managing or working with the QIP program.

5) Section G Prior Focus
   - It is unclear what CMS intends in this section. Do you want to know whether we have done prior QIPs on this topic area or if the Plan is in the 2 or 3 reporting/measurement cycle of the QIP do we report it here as well?

6) Section H Project Goal and Benchmark
   - Definitions are needed for Baseline, internal, external etc. for this entire section.
   - We suggest a companion guide detailing how it aligns with the rating tool or the grade CMS applies to our QIP. Examples here would be helpful.

7) Section I Plan Project Approval
   - Please clarify what CMS means by “responsible person”. Is it the Medical Director or the Project Manager or is it the team that decides on a focus area? A definition would be helpful.

8) Section K.2 Risk Mitigation
   - Clarification and detail on what is to be included in this section is needed. Does it need to align with H.2 or K.1 (barriers encountered) or does K1 tie to this section?

9) Section L Results
   It appears CMS is assuming only one measurement. There is no room for process measurements. In some QIPs we are measuring more than one area. Plans need the ability to adjust this to match what is being measured.

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Document: CMS-2011-0149-DRAFT-0007
PA

Submitter Information

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Organization: Gateway Health Plan

General Comment

RE: Proposed changes to the Chronic Care Improvement Plan and Quality Improvement Program:
Recommmend inclusion of instuctions for completion of each field.
Recommend definition of risk mitigation.
Recommmend definition of actions to be taken by CMS during each subsequent measurement year if sustained improvement is or is not achieved.

COMMENTS OF KAISER PERMANENTE

On Proposed PRA Collection CMS-10209

September 6, 2011

Kaiser Permanente appreciates the opportunity to comment upon the proposed collection of information, "Medicare Advantage Chronic Care Improvement Program and Quality Improvement Project Reporting Tools", published on July 1, 2011 in The Federal Register. Kaiser Permanente is the largest private integrated health care delivery system in the United States, providing health care to approximately 8.6 million members, in nine states and the District of Columbia. Approximately one million of these members are Medicare beneficiaries, served primarily under Medicare Advantage (MA) and Medicare Cost contracts with CMS. Kaiser Permanente comprises the non-profit Kaiser Foundation Health Plan, Inc. and its Health Plan subsidiaries outside California and Hawaii; the non-profit Kaiser Foundation Hospitals, which operates 36 hospitals and over 400 other clinical facilities; and the Permanente Medical Groups, which are independent physician group practices that contract with the Health Plans to deliver care to Kaiser Permanente members. Kaiser Permanente's comments are set forth below. If readers of these comments have any questions or seek further information, they may contact Shelley M. Roth, Senior Director Health Plan Quality, Department of Care and Service Quality, Kaiser Foundation Health Plan, Inc. She may be contacted at 510-271-6483 or at Shelley.M.Roth@KP.org

In this information collection, CMS has included two documents which relate to the statutory and regulatory requirement that each MA organization (MAO) must annually conduct at least one Quality Improvement Project (QIP) and one Continuing Care Improvement Program (CCIP). These two documents are intended to be completed by each MAO with information that CMS may use to evaluate both the value of the proposed QIP and CCIP before they are undertaken, and the results of the QIP and CCIP after they are completed. These two documents are: "The Quality Improvement Project (QIP) Reporting Tool" (QIP Tool) and "The Chronic Care Improvement (CCIP) Reporting Tool" (CCIP Tool). Below, we offer some general comments on these two Tools.

In addition, we ask CMS to reconsider the content of these Tools in light of its August 18, 2011 guidance memorandum to MAOs, "2010 Chronic Care Improvement Program (CCIP) and Quality Improvement Projects (QIP) Results and Information for 2012 CCIP and QIP Submissions." When CMS published this information collection on July 1, the MAO community assumed that the Tools were to be used for the CCIPs and QIPs whose topics the MAOs were free to choose. The Tools would give CMS information with which it could decide whether the topic itself, and the means for establishing, tracking and evaluating the measures for the topic, were appropriate and sufficiently robust. However, in its August 18 memorandum, CMS announced that it would require each MAO to conduct a CCIP on decreasing cardiovascular disease and a QIP on all cause (hospital) readmission in the 2012-2013 cycle. Now that CMS has announced these required QIP and CCIP topics, MAOs may choose to concentrate their efforts and resources on these projects rather than undertaking additional QIPs and CCIPs. Therefore, the primary uses of these Tools will likely be for the QIPs and CCIPs whose topics (and perhaps whose study parameters) CMS has already selected. As a

result, some sections of the proposed Tools will be unnecessary and/or duplicative for such QIPs and CCIPs. CMS should identify these sections and either indicate that they need not be completed when an MAO is conducting a CCIP/QIP on a topic dictated by CMS. or modify them appropriately. We offer our suggestions as to those sections below.

The QIP TOOL

On page 1, the choice regarding "Project Cycle" is not clear. Does this mean that an MAO may choose to do a short cycle project or a project that runs for longer than 3 years? And when the QIP is on all cause readmission, won't CMS dictate the project cycle length? Also, the "Basis of Selection" section on page 3 refers to the "QIP for the year", implying that each QIP is a calendar year in length.

On page 2, the "Based on Model of Care" section is not clear, nor is it explained. What is CMS trying to ascertain here?

On page 3, the "Basis of Selection" section should be deleted when the QIP is for the all cause readmission topic mandated by CMS.

On page 3, the "Budget and Resources" section does not match its counterpart in the QQIP Tool. Should these be the same?

On page 4, the "Risk Assessment" section seems to be mis-named, because the information sought seems to be the particular interventions the MAO intends to implement, and not the risks it expects to encounter.

On page 4, the "Plan Project Approval" section does not indicate the authority or expertise of the person or committee that CMS believes may or must approve the QIP. The title of the section implies that CMS wants the "approver" of the QIP identified, but under the title, there is a reference to the "responsible person", which implies that it is the person managing the QIP. Also, the name of the MAO contact person is required on page 1 of the Tool. Is that person the "approver" or the project manager?

On page 5, in the "Goal and Benchmark" section, the "Timeframe" says it is to be "autopopulated from Plan Section." The only reference to "Timeframe" in the "Plan Section" is in "Target Goal and Benchmark" on page 4. Is this the timeframe that is to be autopopulated into the "Goal and Benchmark" on page 5? And if the Tool is being used for a hospital readmission QIP, won't CMS dictate an actual timeframe?

On page 6, the "Results" section does not clarify whether this grid must be completed for each intervention if the QIP incorporates multiple interventions. And if an MAO has only one or two metrics (as would typically be the case for hospital readmission), but is trying various interventions, then there might need to be multiple versions of this grid. Is that CMS' intent?

The CCIP TOOL

On page 2**,** the "Basis for Selection" should be deleted when the CCIP is for the decreasing cardiovascular disease topic mandated by CMS.

On page 3, the intent of the "Practice Model" is not clear. What is the "Practice" whose "model" CMS is asking about?

On page 3, the "Evidence Based Medicine" section asks the MAO to provide clinical practice guidelines, standards of care, best practices, etc for the topic of the CCIP. When the CCIP is on the CMS-mandated topic of decreasing cardiovascular disease, CMS should either delete this section or provide the inputs for it, so the baseline is the same for all MAOs.

On page 5, the "Budget and Resources" section does not match the counterpart section in the QIP Tool. And in the CCIP Tool, it's not clear whether or why CMS is looking for actual dollar allocations. Is CMS planning to audit an MAO to confirm that it did indeed expend the resources that it said it would, for the CCIP?

On page 5, the "MAO CCIP Responsibility" section is different from its counterpart in the QIP Tool, though they both seem to be asking for the individual who has given his/her "approval" for the project. CMS should use the same terminology in both Tools when it seeks the same information. Moreover, CMS should clarify whether it is seeking the individual who gives "approval" for the project or the individual who manages the project or the individual who is the "contact person" on page 1 of the Tool. In any given case, this could be three different individuals.

On page 7, the "Results" section of this Tool does not match its counterpart in the QIP Tool. Shouldn't they be the same?

Comments to CMS on the Proposed QIP and CCIP Reporting Tools
9/6/2011

ONECare by Care1st HealthPlan of Arizona supports the use of the PDSA Quality Improvement Cycle to conduct Quality Improvement Projects (QIPs); however, the reporting tools for Medicare Advantage Organizations (MAO) and Chronic Care Improvement Program (CCIP) models include areas that are unclear, request information for areas that are difficult to assess, and will require additional resources by MAOs and CCIPs to complete. Some of these resources would be better utilized conducting the QIPs rather than completing paperwork.

CMS estimates that it will take 5 hours for a respondent to complete the CCIP reporting tool and 5 hours to complete the QI project reporting tool. These estimates are low, based on our assessment of the information being requested in the reporting tools as currently designed and extensive experience in actually collecting and reporting quality improvement data and information to regulatory agencies. We estimate the QIP Reporting Tool to take 8 to 10 hours to complete and the CCIP tool, which requires more in-depth narrative (e.g., a discussion of evidence-based medicine related to the project, including current clinical practice guidelines and evidence-based treatment modalities, standards of care, evidence-based best practices, etc.), 10 to 12 hours to complete. These estimates do represent an increase in the number of hours that will be required to complete the tools, compared with the current tools.

Specific areas of concern include the following:

- QIP Reporting Tool
    1. Domain (Background) – It is not clear what measurement, objective or guideline set the domain is derived from; unless this element is clearly defined, the information provided by organizations will be meaningless.
    2. Budget and Resources – Are MAOs expected to provide detailed financial data? These data will be difficult to determine unless an organization intends to hire and/or dedicate specific resources (FTE(s) to the QI project. In most cases, organizations will use existing resources and, since many of the activities will support other MAO activities, it will be difficult and time-consuming to quantify the financial impact of the QI interventions. We recommend eliminating this section; budget and resource considerations should be incorporated into the Basis of Selection and Summary of Findings/Conclusions sections as appropriate.
    3. Budget and Resources – It is unclear how the Priority Assessed field relates to the financial and resource fields. QIP selected based on the priority of a topic and/or expected outcome should be discussed in Rationale for Selection (E3) above. We recommend eliminating this section; budget and resource considerations should be incorporated into the Basis of Selection and Summary of Findings/Conclusions sections as appropriate.
    4. Prior Focus (G) – This section should be eliminated; some of the information may be included in Basis of Selection and/or the Risk Assessment (H2) sections.
    5. Project Goal and Benchmark (H) – The meaning of a “baseline” benchmark is unclear. Is this the actual baseline rate as derived from the measurement methodology or a pre-measurement benchmark (if the latter, the organization could identify the source)?

6. Project Goal and Benchmark -- What is meant by Inclusion Criteria in relation to Interventions? Presumably, all beneficiaries would be included in a particular intervention.
7. Risk Mitigation – This section should be revamped and identified as Measurement Methodology. Since it will be important to understand how baseline and successive measurements are calculated, this section should include the specific criteria for Population, Indicator, Sampling Methods/Selection if used, Exclusions, Numerator, Denominator, Analysis Plan, etc.
8. Action Plan Description (O) – If the project is successful and/or the goal is met, how is this information useful to CMS? Next Steps, as identified above, should be self-explanatory.

- CCIP Reporting Tool
  1. As much as possible, given the differences in types of projects, this tool should be consistent with the QIP Reporting Tool.
  2. The specific methods and topics related to Patient Self Management Education (B4) should be moved to the "Do" section.
  3. Outcome Measures and Interventions – It is not clear whether a specific rate for a goal should be provided or whether the organization is simply identifying improvement in a particular area (e.g., clinical, utilization, financial, etc.); likewise with the benchmark. The meaning of a "baseline" benchmark is unclear. Is this the actual baseline rate as derived from the measurement methodology or a pre-measurement benchmark (if the latter, the organization could identify the source)?
  4. Outcome Measures and Interventions/Measurement Methodology –Since it will be important to understand how baseline and successive measurements are calculated, this section should include the specific criteria for Population, Indicator, Sampling Methods/Selection id used, Numerator, Denominator, Analysis Plan, etc.
  5. Budget and Resources –These data may be difficult to determine, as organizations likely will use existing resources that support other CCIP activities; it will be difficult and time-consuming to quantify the financial impact of the QI interventions. We recommend eliminating this section; budget and resource considerations should be incorporated into the Basis of Selection as appropriate.
  6. Intervention (Outcomes Measures and Intervention section, as well as #1 of "Do" section – How will organizations report information when more than one intervention is used?
  7. Results Table – Sampling/Percent of Total Population and Exclusions should be discussed in the Measurement Methodology; this column should be eliminated as the final sample size will equal the denominator.
  8. Act – This section should mirror the Act section of the QIP Reporting Tool.

ONECare by Care1st Health Plan of Arizona appreciates CMS' efforts to streamline the CCIP and QIP reporting processes while providing a meaningful tool for data collection; however, we request that the agency consider further streamlining the forms for the more effective use of resources to benefit Medicare beneficiaries.

SNP Alliance Comments

Proposed MA Tools for QIP and CCIP

September 6, 2011

On behalf of the SNP Alliance, thank you for the opportunity to offer comments on the new draft reporting tools for MA plans to use in submitting Quality Improvement Project (QIP) and Chronic Care Improvement Program (CCIP) data. In the cover letter accompanying the release of Chapter 5 of the Medicare Managed Care Manual relating to quality, CMS indicated that "it will be issuing new guidance later this year on changes to the CCIP and QIP templates, scoring methodology, benchmarks, and any CMS identified CCIP and/or QIP topics." Some of our members heard from their CMS ROs that this guidance would be available in November.

As a result of CMS' plans to provide additional guidance on the QIP and CCIP templates and requirements, we are requesting that CMS extend the comment period to 30 days beyond the release of the additional guidance, which we understand will take the form of an instruction guide on the QIP and CCIP. This will allow SNPs to better understand the type of information CMS is seeking in these new tools. While we held a conference call with SNP Alliance members last month to obtain specific feedback on the new tools, plans indicated that the revised tools are much more ambiguous than the old templates and that it would be difficult to effectively evaluate or comment on these tools without an instructional guide to help them understand the tools. Based on the number of questions being raised by SNP members on the call about various aspects of the tool, the Alliance agrees that this approach would be much more efficient than listing several dozen questions about the information being sought in the reporting tools. We are hopeful the instruction guide will answer the majority of the questions. Questions not addressed by the guide and concerns that may be raised as a result of clarifications provided by the guide could be addressed in follow-up comments, assuming CMS agrees to extend the comment period or provide an additional comment period following issuance of the instruction guide in November.

While we are seeking an extended or additional comment period, we have some general questions and a few general comments. We also would like to identify some examples of the types of clarifications our members hope to obtain through the instruction guide. These questions, comments and examples are outlined below.

General Questions

1. Do QIPs for SNPs need to focus on SNP models of care?
2. Do plans need to develop separate QIPs and CCIPs for each Plan Benefit Package or are QIPs and CCIPs developed at the contract level and applied to each PBP within the contract or H number? Chapter 5 used to explicitly state that these tools were applied at the contract level, but the updated Chapter 5 no longer clarifies this point.

3. Will QIPs and CCIPs be submitted electronically? If so, there will need to be enough space for the information. We understand the current HPMS has a limited number of spaces and plans sometimes have difficulty providing complete information.
4. Will plans be required to convert existing projects already underway into the new reporting format or may they complete existing under the original report structure?
5. Please clarify reporting requirements moving forward. Will plans need to submit QIP and CCIP data next in 2012, as opposed to 2011? Will plans be expected to use their 2010 scores as a benchmark for measuring quality in 2012? Will there be a comment period after scores are released, similar to S&P, etc.?

Examples of Specific Clarifications on QIP Tool

1. Table F: Budget and Resources (Page 3)
   - What does CMS mean by financial resources? Is CMS seeking overall costs for the QIP or a breakdown of costs for each intervention (e.g., how much did it cost for a mailing to distribute educational materials)? Some of this information may be considered proprietary by plans.
   - What level of detail is CMS seeking regarding "Resources?" Is CMS looking for a listing of the type of resources used such as internal staff, contractors and technology or for a cost breakdown of each type of resource as well?
   - Under "priority assessed," please define and clarify each of the priority options in greater detail and how they relate to interventions.

2. Table H.1: Project Goal and Benchmark (Page 4)
   - Please define/clarify "rationale" under H.1. Is CMS seeking the rationale for the target goal and benchmark; how plans identify the goal and benchmark?
   - Please define internal (e.g., prior plan scores?) and external (i.e., national data on all Medicare enrollees or a specific target group?).
   - Please define "inclusion criteria" – does this refer to the criteria the plan used to determine which beneficiaries to include in the project and intervention?
   - Please clarify "methodology" – Does this refer to the method for determining the inclusion criteria? Or determining the intervention? For example, if a planned intervention for diabetes care is education about diabetes care, is CMS looking for information about how it decided whether to educate via phone calls, newsletters, a mailing of education brochures, etc.?

Specific Comments

1. **Duplication between QIP, CCIP and other Measures**: The SNP Alliance has commented many times on the need to streamline reporting requirements for SNPs since they report all standard MA data in addition to model of care and structure and process data as well as Medicaid data for duals. For example, since CMS allows plans

to select a clinical QIP, SNP Structure and Process measure #3 is for clinical quality improvement projects, and the CCIP requires plans to focus on a particular chronic condition, why not allow SNPs to submit a single set of QIPs to Medicare and Medicaid that focuses on the clinical problems of the target population instead of requiring them to submit QIPs, CCIPs, S&P 3 and Medicaid QIPs/PIPs? This would significantly reduce the data burden for SNPs, CMS, NCQA and states and could be done in such a way as not to jeopardize regulator's ability to monitor performance or beneficiary outcomes.

2. **Completion Time:** At the bottom of the first page of the QIP and CCIP, it indicates that "the time required to complete this information is estimated to average 5 hours per response." We are not sure what this information will be used for and why we are asked to submit these comments to another part of CMS. Also, it isn't clear whether the statement is suggesting it will take 5 hours to complete the tool once all the information has been gathered and research has been conducted – or whether the whole process will take only 5 hours. If the latter case is the assumption, the 5 hour timeframe significantly underestimates the amount of time it will take plans to complete these two tools from start to finish. In fact, we understand that CMS has indicated to contractors that it assumes it will take them 5 hours to review each submission. This underscores SNP members' belief, based on past reporting experience, that it will take much longer than 5 hours to complete the tools.

3. **Existing Projects**. We request that plans be permitted to complete and report on existing QIPs and CCIPs under the template the plan originally used for the project. It would be extremely cumbersome attempting to convert existing projects to a new template or reporting format in the midst of a project. Further, we believe it would compromise reporting and analysis of interventions/outcomes across re-measurement periods if the type of information collected or measures change.

4. **Target Populations.** CMS indicated that it may select a specific population target or project for all plans to report on in addition to the individual projects plans select. Since SNPs are specialty plans that target specific populations, we urge CMS to allow SNPs exclusively to focus projects on the target populations served, not to be required to study populations or projects that may not be relevant to their targeted focus.

5. **CCIPs for ISNPs.** Please clarify what a quality "improvement" project means in relation to institutional SNP beneficiaries where there is a very small likelihood of improving individual beneficiary health status. Would CMS consider a project to reduce falls, incontinence, decubitus ulcers, etc. appropriate "improvement" projects? Or a project to slow the rate of decline for a particular condition or population-based metric?

Comments Table for QIP/CCIP Tools

QIP Reporting Tool Comments	CCIP Reporting Tool Comments
All items in F, G, H, K and L should be numbered similar to E, for example F.1, H.1.a, etc. Do Section: The title Goal and Benchmark in K.1 should be changed to Barriers Encountered During Implementation. Act Section: O. Action Plan Description Next Steps should auto populate from the N. Next Steps items selected.	All items in the Reporting Tool should be numbered in all sections similar to section B.1 for easy identification. Plan Section, B5 Outcome Measure and Interventions: Goal and Benchmark should be separate because both are required. Do Section: Remove the Cycle Period because it is already captured on the first page. Do Section: Remove 2. Results or Findings. This is captured in the Study Section. Study Section: Move “Analysis of Results or Findings” below the table and allow more space for the narrative.

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AZ

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General Comment

On the QIP and the CCIP, the terms "benchmark" and "goal" are confusing. Would you please provider a clear definition of these terms as they apply to the CCIP and QIP.

2. On the QIP Reporting Tool under PLAN:D. Based on Model of Care- the question does not make sense. Are you asking whether the plan is based on the model of care?

2011 Chronic Care Improvement Program Template Review
8/18/11

Early in 2011, UAHP received scoring criteria in the revised Chapter 5 of the Medicare Manual for the Chronic Care Improvement Program (CCIP). On August 18, 2011, UAHP received a memorandum from CMS identifying a new template, and additional reporting requirements for this program.

To facilitate the realignment and modifications to the existing program, the Quality Team reviewed the current CCIP program through the CMS Compliance Indicator Scoring as outlined below.

Evaluation of CCIP and Scoring Criteria
The evaluation and scoring criteria are outlined in Chapter 5 of the revised Medicare Manual. The evaluation methodology used for review of CCIP is based on the degree to which the program improves and impacts the health status of the plan members.

1. **CCIP Compliance Indicator 1: (15%): Target Population and Method of Identifying Eligible Enrollees Criteria**
    a. ***This is identified in B1. "Population Identification Process" on the new CCIP template***

2. **CCIP Compliance Indicator 2 (15%): Method for Enrolling Participants and Participation Rates Criteria**
    a. ***This is identified partially in B1d. "Enrollment Method but there is nowhere in the new template that allows for submission of the "Participation Rates Criteria"***

3. **CCIP Compliance Indicator 3 (15%): Whether the CCIP is designed to Improve Health Outcomes Criteria**
    a. ***This is identified in "Evidence Based Medicine" and B3. "Practice Model". However B2 and B3 are very clinically based rather than community health or case management and there is no indication of requesting specifics on how either would improve health outcomes or what that criteria is..***

4. **CCIP Compliance Indicator 4 (10%): Data Sources Used to Identify Need for CCIP Criteria**
    a. ***This is identified in "Section A. Basis for Selection": "Data Source(s) for Selected Chronic Condition". However there is no space to show validity or reliability.***

5. **CCIP Compliance Indicator 5 (15%): Criteria for CCIP Compliance Indicator 5 Intervention Criteria**
    a. ***This is identified in B5. "outcome Measures and Interventions", the "Program Implementation, Review and Revision" and "Next Steps"***

6. **CCIP Compliance Indicator 6 (15%): Program Monitoring and Delegation Oversight Criteria**
    a. ***This is identified in Section B6."Communication Sources including the interdisciplinary Care Team and Patients" and "Program Implementation, Review and Revision" and "Results"***

7. **CCIP Compliance Indicator 7 (15%): Outcome Measures: Criteria**
    a. This is identified in "Next Steps", "Program Implementation, Review and Revision", "Results", "B5. Outcome Measures and Interventions"