Medicare Advantage Quality Improvement Project (QIP) & Chronic Care Improvement Program (CCIP)

Medicare Drug and Health Plan Contract Administration Group

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QIP/CCIP

Presentation Overview

- QIP/CCIP Background
- CMS Quality Strategy Goals
- Reducing All-Cause Hospital Readmissions
  - Results & Lessons Learned
- Mandatory QIP Topic
  - Promote Effective Management of Chronic Disease
- Mandatory CCIP Topic
  - Support Million Hearts
- 2016 Plan Section Submissions
  - Overview
- MA Quality Initiatives
  - Current and future direction

QIP Background

- **Quality Improvement Program Requirements**
  - CMS regulations 42 CFR §422.152
  - Quality Improvement Project (QIP)
  - Chronic Care Improvement Program (CCIP)
  - Requires progress be reported to CMS
- Focus on Interventions and Outcomes
- Utilize the Plan, Do, Study, Act (PDSA) quality improvement model

CCIP Background

CCIP Mandatory topic (5 years)

- Reducing the incidence and severity of cardiovascular disease
- CCIPs must be clinically focused
- Supports the national HHS initiative—Million Hearts
- ABCS of heart disease
  - **A**spirin
  - **B**lood pressure control
  - **C**holesterol management
  - **S**moking cessation

CMS Quality Strategy Goals

1. Make care safer by reducing harm caused in the delivery of care.
2. Strengthen person & family engagement as partners in their care.
3. Promote effective communication and coordination of care.
4. Promote effective prevention and treatment of chronic diseases.
5. Work with communities to promote best practices of healthy living.
6. Make care affordable.

Reducing All-Cause Hospital Readmissions

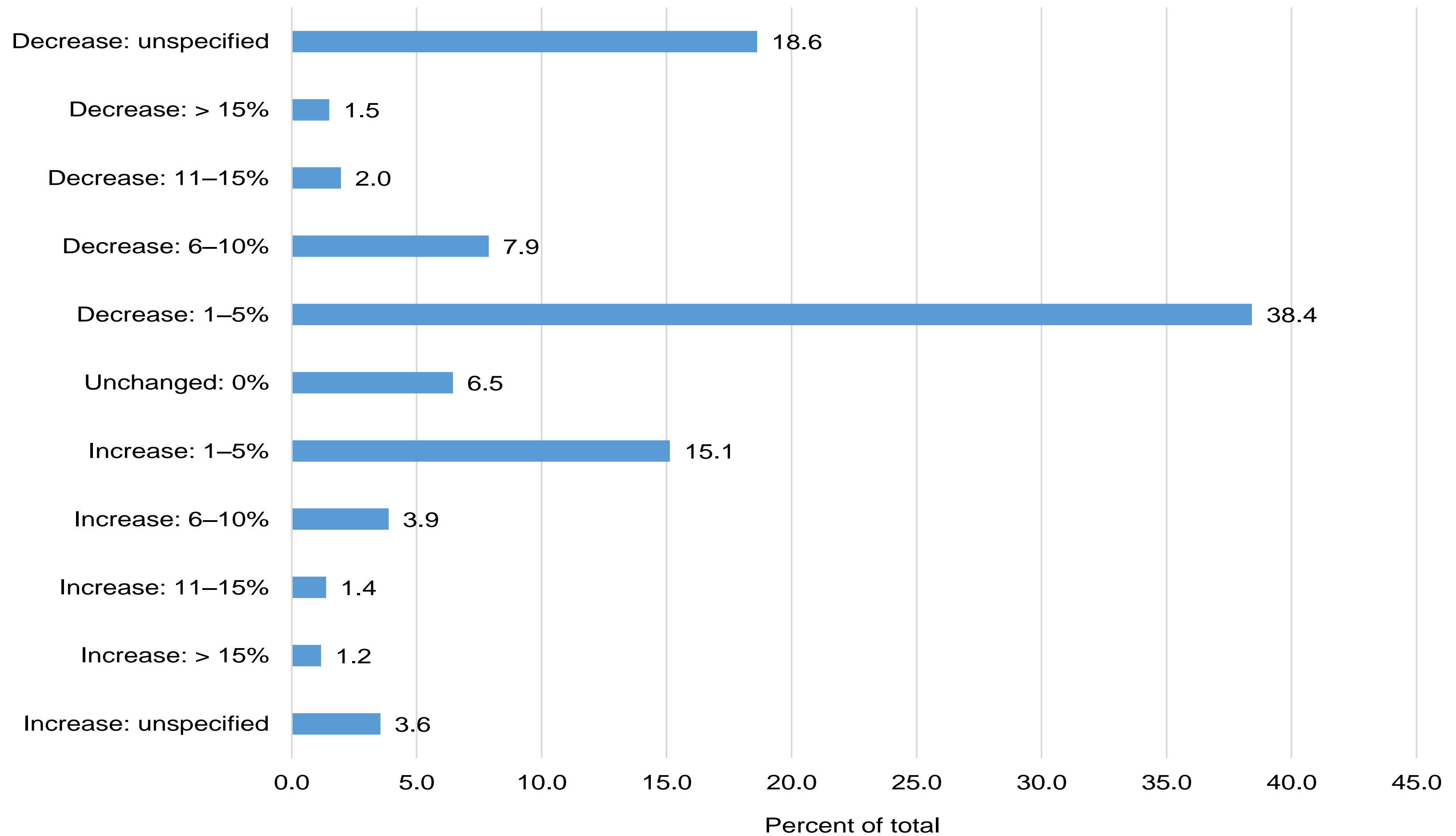
- Mandatory QIP Topic Implemented 2012
- Independent Analysis
- Assess level of success in reducing hospital readmissions
  - Common barriers & mitigation strategies
  - Identify best practices & lessons learned
- Recommendations for MAOs & CMS
  - Improving data quality & analytical capabilities

Reducing All-Cause Hospital Readmissions

Results

- 71% of QIPs reported a reduction in readmission rates
- 41% of QIPs reported meeting their goal

Changes in Readmission Rates



Reducing All-Cause Hospital Readmissions

Barriers

- Health care team issues, communication, non-compliance, technology, external influences, medications, support systems, transportation & financial

Mitigation Strategies

- Health care team coordination, communication, case management, IT solutions, post-hospital discharge care, follow-up appointment coordination

Reducing All-Cause Hospital Readmissions

Best Practices & Lessons Learned

- Improving communication/provider engagement
- Connecting with enrollees is vital
- Technology enhancements/timely data transmission
- Developing better analytical infrastructure/identifying risk factors
- Case management/Disease management
- MAO staff training
- Focus on weekend discharges

Reducing All-Cause Hospital Readmissions

Best Practices & Lessons Learned (continued)

- **Primary Care Provider (PCP)**
  - Increased involvement, more frequent visits for preventive care and appropriate treatment
- **Education**
  - Improve education of case managers, caregivers in the community & primary care providers
  - End of life care and decision making
- **QIP Development**
  - Set goals that are measurable, identify metrics, analyze data and implement interventions accordingly

QIP Mandatory Topic
Promote Effective Management of Chronic Disease

QIP Objectives

- Support the HHS and CMS Quality Strategy Goals;
- Advance CMS' efforts to assure that enrollees receive high quality care & care coordination;
- Effectively manage care for enrollees with chronic conditions;
- Ensure appropriate preventive services for specific conditions;
- Have favorable effects on health outcomes and enrollee satisfaction; and
- Eliminate disparities in care.

Promote Effective Management of Chronic Disease

Effective management of chronic conditions helps to:

- Slow disease progression;
- Prevent complications and development of comorbidities;
- Prevent emergency room (ER) encounters and inpatient stays;
- Improve quality of life for the enrollee; and
- Increase cost savings to the plan and the enrollee.

2016 QIP Plan Submissions

Overview

- Chronic Conditions Selected
- Target Goals
- Intervention types
- Opportunities for Improvement

CMS Identified Chronic Conditions (QIP)

Chronic Condition	Selection Frequency
*Atrial Arrhythmias	1
Behavioral Health Condition-Anxiety Disorders	0
Behavioral Health Condition-Bipolar Disorders	0
Behavioral Health Condition-Major Depression	18
Behavioral Health Condition-Schizophrenia	0
Cancer	2
Chronic Kidney Disease (CKD) Stages 4 or 5	1
*These conditions may only be selected if they are not part of a current CCIP initiative	

CMS Identified Chronic Conditions (Continued)

Chronic Condition	Selection Frequency
Chronic Obstructive Pulmonary Disease (COPD) and or Asthma	19
*Congestive Heart Failure (CHF)	4
*Coronary Artery Disease (CAD)	0
Dementia	0
*Diabetes	29
End Stage Renal Disease (ESRD)	2
HIV/AIDS	0
*Hypertension	6
Osteoporosis	20
Parkinson Disease	0
*These conditions may only be selected if they are not part of a current CCIP initiative	

2016 QIP Plan Submissions

Examples of Target Goals

- Improved HbA1C testing and control
- Improve symptom management w/ major depression
- Improve screening and management
  - Cancer
- Improve medication adherence
- Reduce hospital admissions/readmissions
  - CHF, COPD
- Engage enrollees in Case Management/Disease Management programs

*All Target Goals must have a quantifiable aim

2016 QIP Plan Submissions Intervention Types

Intervention	Selection Frequency
Provider Education	32
Enrollee Education	40
Medication Adherence	30
Reward and Incentive Program	6
Care Coordination	24
Enrollee Outreach	13
Plan Outreach to Providers	18
Disease Management	22
Home Visits	3
Promoting Lifestyle Changes	14
Other	27

2016 QIP Plan Submissions

Examples of Interventions

- Care coordination/care transitions
- Medication compliance
- Promote preventive care/screenings
- Help enrollees navigate health care system, receive appropriate care and link to community resources
- Disease management programs that educate enrollees on:
  - How to manage their condition;
  - When to seek medical care; and
  - Communicate with their providers.

2016 QIP Plan Submissions

Opportunities for Improvement

- Failure to provide adequate description of QIP
- Lack of Quantifiable/Measurable Target Goals
- Overall lack of detail
  - Inadequate descriptions
    - Plan population;
    - Baseline; and
    - Vague interventions

QIP/CCIP

Recent changes

- QIP Annual Update submission window moved to January 2017
- Minor enhancements to the HPMS QIP Module
- MA Plans are no longer required to submit reports on CCIPs
- CCIP requirements streamlined to mirror current QIP requirements

QIP/CCIP
Current and Future Direction

- Where do organizations need to be positioned in relation to the QIP/CCIP programs?
  - Support CMS Quality Strategy Goals;
  - Emphasis on care coordination as integral to improved outcomes;
  - Increase provider engagement; and
  - Address health care disparities.
- How does CMS measure or determine value of these quality initiatives?
  - Analysis of outcomes data;
  - Number of enrollees impacted;
  - Identify/share best practices;
  - Improved HEDIS/STAR Ratings measures?

QIP/CCIP 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/CMS-Quality-Strategy.html

HPMS QIP User Guide

https://hpms.cms.gov/app/login.aspx?ReturnUrl=%2fapp%2fhome.aspx

HPMS login > Quality and Performance > QIP > Documentation > User Guide

Medicare Part C Policy Mailbox (website)

https://dpap.lmi.org