#	Commenter	Tool (CCIP/ QIP)	Section	Timing of Submission or Burden of Hours	Requests for Instructions	Specific Change to Text or Type of Option in Tools	Comment
							General
1	AHIP/Kaiser	Both			x		Commenters want tool instructions issued with tools to judge burden.

2	AHIP/WellPoint/ HealthPartners	Both			x		Commenters recommend providing the following guidance with the tools: 1) examples of populated templates; 2) scoring methodology; 3) guidance on submission of ongoing QIPs/CCIPs; and 4) reporting deadlines.
3	Wellpoint	Both			x		Commenter wants guidance on terminating existing QIPs.

4	Wellpoint	Both			x		Commenter wants to know the relation of the scores to the star ratings.
5	HealthPartners	Both					Commenter is requesting a glossary of word/term definitions to assist in creating consistent interpretation across plans.
6	AHIP/HealthPartners	Both					Commenters want more clarity on the RO review role

			QIP				
7	AHIP	QIP	A		x		AHIP wants instructions on how to complete "Identification #"
8	AHIP	QIP	A		x		AHIP wants instructions on how the "Project Cycle" field relates to PDSA
9	Kaiser	QIP	A		x		Kaiser wants CMS to distinguish between Baseline and Year 1 in Project Cycle

10	AHIP/ Kaiser	QIP	B		x		AHIP wants instructions on how to complete the "Domain" field.
11	Kaiser/Wellpoint	QIP	D		x		Kaiser wants clarification on Section "Based on Model of Care" (does this apply to SNPs only)

12	Kaiser	QIP	E		x		Kaiser wants to know how much detail is required in Basis of Selection

13	AHIP	QIP	F		x		AHIP wants the definitions revised under "Priority Assessed" to identify how they relate to either QIP or Intervention

15	Kaiser/ AHIP	QIP	G		x		Commenters want CMS to distinguish between G1d and G2a
16	Kaiser	QIP	G		x		Will G1a be auto populated using G1d data?

17	Kaiser	QIP	F/G			x	In previous QIP templates, if an MAO used HEDIS measures for any QIP, the MAO was exempt from filling out certain portions of the QIP template report, because HEDIS measures are nationally recognized measures. For example, MAOs didn't fill out the methodology and inclusion criteria sections because the HEDIS methodology is known, standardized, and generally accepted. The cycle year is also designated by HEDIS. The first items listed in Subsections below are well-known and it would be duplicative work to have to report on these: F.1. – Cycle Year; G1e – Inclusion Criteria; G1f – Methodology. CMS should designate these Subsections as Not Applicable when MAOs use HEDIS measures.

18	Wellpoint	QIP	G2d and J2		x		Wellpoint wants examples of what is expected in the mitigating plan sections
19	Kaiser	QIP	H		x		Kaiser wants to know if approval is limited to the MAO's medical director, or may a designee of medical director, or a health plan senior quality leader, approve projects

20	AHIP	QIP	G1b.		x		AHIP wants guidance explaining the terms "Baseline/Internal/External and their benchmarks
23	Kaiser	QIP	J		x		Kaiser wants to know if the fields in Subsection J2 “Mitigation Plan for Risk Assessment” be auto-populated from above “Plan” Subsections in J1.
24	AHIP	QIP	J2e		x		AHIP wants clarification on the definition of risk mitigation and measurement methodology (as compared to methodology in section G1f)

25	AHIP/Kaiser/ Wellpoint	QIP	K		x		AHIP wants clarification on the Intervention section. It appears this section will auto populate but more than one intervention is allowed so please advise from which. How will CMS handle multiple interventions. Does each intervention need different inclusion criteria?
26	AHIP	QIP	K		x		AHIP wants to know how CMS will evaluate sample size
27	Wellpoint	QIP	K		x		Wellpoint wants CMS to provide guidance on how plans should identify continuous, ongoing improvement activities (interventions) that exist outside of the submission cycle.

28	Wellpoint	QIP	M2		x		Wellpoint wants CMS to provide additional detail on what must be included in the Root Cause Analysis to ensure that plans are interpreting this requirement consistently across the industry.
							CCIP
29	AHIP	CCIP			x		AHIP wants instructions on whether CCIPs can be longer/shorter than 5 years

30	AHIP	CCIP	B3		x		AHIP wants to know how much detail should be included in the Care Coordination Approach Section
31	AHIP	CCIP	B2		x		AHIP wants instructions on what to include in "Evidence Based Medicine" section

32	AHIP	CCIP	B5		x		AHIP wants guidance explaining the terms "Baseline/Internal/External and their benchmarks"

33	Kaiser/Wellpoint	CCIP	B5		x		Commenter wants to know how to report on multiple interventions
34	AHIP	CCIP	D		x		AHIP wants instructions on who in the org should complete this section (and recommends this should be same instruction for QIP tool)

35	AHIP	CCIP	E2		x		AHIP wants to know how to complete the Intervention section in Do. Also it does not appear this would allow for multiple interventions to auto populate. Plans expect to utilize multiple interventions to approach one goal; how can this tool accommodate that?
36	Kaiser	CCIP	E			x	Kaiser wants CMS to auto-populate Subsections E1a and E1b from prior Subsections B4a and B4b
37	Wellpoint	CCIP	E6				Commenter wants to know what would qualify as anticipated impact?

38	AHIP	CCIP	F5		x		How will CMS evaluate sample size
39	AHIP	CCIP	F6 and F7		x		AHIP wants to know when these will "not be applicable" and can be skipped?

40	Wellpoint	CCIP	B1a		x		Wellpoint wants guidance to include a description of the demographic information CMS expects from plans to clearly and adequately identify the target population.
41	Wellpoint	CCIP	B5e		x		Wellpoint wants clarification of whether prevalence rates from national and regional sources must be included in the CCIP document to justify the reasons for improvement of the population.
42	Wellpoint	CCIP			x		Wellpoint wants clarification of the methods CMS expects plans to use to validate their internal claims data

43	Wellpoint	CCIP			x		Wellpoint wants clarification on the required topic. Is it the intention for this program to help those with the disease better manage their condition, or whether primary prevention of the disease is also included in the goal? WellPoint recommends this topic be focused on the former

Response
Accept. We will release detailed instructions for both tools once the CCIP and QIP forms have been approved by OMB.

Accept. We will release detailed instructions for both tools when the CCIP and QIP forms have been approved by OMB. The instructions will include information on populating templates and submission of ongoing QIPs/CCIPS. Scoring methodology and other guidance was provided during CCIP training conducted on February 29, 2012 and QIP training on March 14, 2012. Additionally, we will hold a tool specific webinar in which specific examples will be provided. An HPMS memo announcing the new training dates and reporting deadlines will be released spring/summer 2012.
MAOs should terminate their QIP as appropriate according to their project cycles. This determination should be made by the plan.

In the future, CMS may consider including elements of the CCIPs and QIPs in the MA star ratings, which determine the level of quality bonus payments to MA plans.
Accept. We will release detailed instructions for both tools when the CCIP and QIP forms have been approved by OMB. These instructions will include a glossary of word/term definitions.
The RO review role was further explained during a CCIP training conducted on February 29, 2012 and a QIP training on March 14, 2012. Additional information regarding the RO review will be provided as part of additional trainings to be conducted after the CCIP and QIP forms are approved by OMB.

The instructions will indicate that each SNP product must have its own unique QIP. The "Identification #" refers to the plan benefit package number (Plan ID) offered under a contract. A single QIP may be conducted for all coordinated care plans offered under a contract. These plans will be bundled and identified as "Non-SNP." The MAO will not designate the identification numbers; those numbers will be based on the plans offered under a particular contract.
The PDSA represents a complete project cycle. However, only the "plan" section will be submitted for an original QIP; the plan section may <u>not</u> subsequently be edited. Therefore, for ongoing QIPs, the MAO will update the Do, Study and Act sections as appropriate for the current project year.
The baseline year is the first year that the project is implemented. Year 1 refers to the first year after project implementation, or the year following the baseline year.

The "Domain" represents an area of focus for the QIP and serves as the basis for the develepmont of the QIP topic. The response should fit into one of the 7 quality domains: Safer Patient care, Patient Centered Care, Effective Care Coordination, Effective Prevention and Treatment, Promotion of healthy living, Effective Communication, and Improving Affordability.
This section only applies to SNPs to the extent a QIP relates to the established MOC for the SNP. This is not applicable to non-SNP plan types because the MOC is unique to MA SNP products. The instructions provide additional detail regarding the applicability of this section.

There is a 4k character limit in each subsection under the heading "Basis for Selection". MAOs should utilize the instructions which will describe what is to be included in each field under this heading. Additionally, we will conduct a webinar that will provide detailed information regarding the tool, including information that is expected in each designated field. An HPMS memo announcing the new training dates will be released spring/summer 2012.

Accepted. The "Priority Assessed" element refers to prioritizing interventions in the plan section. Our definition, which will be included in the instructions, is as follows:
In the “Priority Assessed” element, identify the level of priority assessed that was given to each intervention used to address the issue. Identify the level of priority in terms of Low, Medium, or High where each is defined as follows:
• Low priority does not require immediate attention.
• Medium priority requires watching the issue for progression.
• High priority requires immediate attention to resolve the issue.
After indicating the priority level, describe why the particular priority level was selected.

G1d requires MAOs to provide a detailed explanation of the planned intervention(s). G2a is the identified intervention, which is auto populated from G1d. G2a is associated with the risk assessment component.
No, it will not. G1a and G1d are distinct fields.

Rejected. CMS has designed these tools to assess the MAO's overall projects. They are not specific to any given measure (e.g. HEDIS®). MAOs should report the project cycles, methodology, and inclusion criteria that underlie their overall QIP and not those specific to any particular data measure.

Accepted. This will be included in upcoming tool instructions that will be released when the CCIP and QIP forms have been approved by OMB. Additionally, we will hold a tool specific webinar in which specific examples will be provided. An HPMS memo announcing the new training dates will be released spring/summer 2012.
Yes, either a designee of the Medical Director, the Medical Director, or a person of authority at the MA Plan level must approve the plan for the program before it can be submitted for approval by CMS. This is addressed in the instructions for the tool.

Accepted. This will be included in upcoming tool instructions that will be released when the CCIP and QIP forms have been approved by OMB. Additionally, we will hold a tool specific webinar in which specific examples will be provided. An HPMS memo announcing the new training dates will be released spring/summer 2012.
No, J2 is specific to the mitigation plan, not the overall goal of the QIP (J1).
The risk mitigation and measurement methodology in section J2e is specific to the mitigation plan, not the overall goal of the QIP (as in section G1f).

This information will be included in the instructions and in the upcoming training. MAOs will be able to include up to three interventions per QIP. Each Intervention will auto populate throughout the sections. Each intervention will need inclusion criteria input into the tool but this may be the same as another intervention targeting the same overall QIP goal.
At this time, CMS will not evlauate or score the sample size. MAOs have the discretion to report sample sizes appropriate for their populations and interventions.
CMS expects MAOs to report their ongoing quality improvement activities on an annual basis as appropriate according to their project cycles. MAOs should examine and review their internal processes to address gaps, weaknesses, and areas for improvement.

CMS will not be prescriptive about how MAOs conduct their root cause analysis, which involves an investigation to determine and understand the reason(s) why a goal was not met or progress was not made or a specific outcome was not realized. The specific approach is to be identified by the plan, which is in the best position to determine the appropriate method.

The required CCIP for cardiovascular disease must be 5 years in duration because it is intended to support HHS's million hearts initiative. However, additional CCIPs may be longer or shorter than 5 years, as determined by the MAO.

This will be included in upcoming tool instructions that will be released when the CCIP form has been approved by OMB. Additionally, we will hold a tool specific webinar in which specific examples will be provided. An HPMS memo announcing the new training dates will be released spring/summer 2012.
Evidence-Based Medicine is the integration of the best research evidence with clinical expertise and patient values to make clinical decisions. Evidence-Based Medicine ensures consistency in treatment across the targeted population. For “B2. Evidence-Based Medicine,” provide a detailed and in depth description that is consistent with the overall goal of the program. This will be included in upcoming tool instructions that will be released when the CCIP and QIP forms have been approved by OMB. Additionally, we will hold a tool specific webinar in which specific examples will be provided. An HPMS memo announcing the new training dates will be released spring/summer 2012.

Baseline benchmark is the first measure used as a point of reference in which a program can be measured, compared, or judged. Internal benchmark is the data used from the plan's own data sources (e.g., administrative data or claims data) for comparison. External benchmark is the data obtained from sources outside of the MAO (e.g., national or regional benchmarks). At the end of the measurement cycle, this data is used to measure against internal results to determine the level of success or failure of the program. More information about this will be included in upcoming tool instructions that will be released when the CCIP and QIP forms have been approved by OMB. Additionally, we will hold a tool specific webinar in which specific examples will be provided. An HPMS memo announcing the new training dates will be released spring/summer 2012.

The Outcome Measures and Interventions table may be repeated a total of three times in order to identify more than one intervention. More information about this will be included in upcoming tool instructions that will be released when the CCIP and QIP forms have been approved by OMB. Additionally, we will hold a tool specific webinar in which specific examples will be provided. An HPMS memo announcing the new training dates will be released spring/summer 2012.

Figure D refers to CMS Regional Office Approval. The appropriate Regional Office Account Manager from CMS will complete this section. More information about this will be included in upcoming tool instructions that will be released when the CCIP and QIP forms have been approved by OMB. Additionally, we will hold a tool specific webinar in which specific examples will be provided. An HPMS memo announcing the new training dates will be released spring/summer 2012.

An MAO can enter up to three interventions per CCIP. Each intervention will auto-populate across sections. The scoring will be on the overall outcome of the CCIP and includes how each intervention impacts the overall outcome.
Rejected. The description of patient self-management and provider education does not auto populate because these descriptions might change from the "PLAN" to the "DO" sections. MAOs will not be able to modify elements that auto populate.
CMS expects MAOs to develop anticipated impacts by utilizing and citing either plan experience or reviews of literature.

At this time, CMS will not score the sample size. MAOs should report sample sizes appropriate for their populations and interventions.
These sections will not be applicable when re-measurement is not completed; re-measurement periods are optional.

MAOs have discrection regarding what to report in terms of target population. However, MAOs should report demographic characteristics they believe are pertinent to their overall CCIP goals.
MAOs may use internal or external benchmarks (e.g. national/regional prevalence rates) to indicate improvement, as they deem appropriate.
CMS is not specifying any particular method that MAOs must use to validate their claims data for their CCIPs.

The current tools are designed to allow MAOs to implement projects that focus on aspects of disease management and prevention, including prevention of progression to advanced disease states.