
HEALTH PLAN MANAGEMENT SYSTEM

CHRONIC CARE IMPROVEMENT PROGRAM (CCIP) USER GUIDE

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INTRODUCTION

All Medicare Advantage Organizations (MAOs) must conduct a *Chronic Care Improvement Program (CCIP)* as part of their required Quality Improvement (QI) program. The QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 CFR §422.516(a) and §423.514 for Parts C and D, respectively.

MAOs may conduct a single *CCIP* for all non-special needs coordinated care plans offered under a contract. However, MAOs must identify a unique *CCIP* for each Special Needs Plan (*SNP*) offered, including multiple *SNPs* of the same sub type. For example, if a MAO offers multiple Dual-eligible *SNPs* (*D-SNPs*) under a single contract, that MAO must identify a unique *CCIP* for **each** *D-SNP* offered that appropriately addresses the *target population*.

MAOs must submit the *CCIP(s)* to the Centers for Medicare & Medicaid Services (CMS) and report progress annually for review. CMS will release submission deadlines on an annual basis.

For CY 2012, CMS is requiring that each MA plan conduct a *CCIP* focused on reducing cardiovascular disease. This project is to be implemented over a 5-year period. At this time, CY 2012 *CCIP* submissions will include the Plan section only. The Do, Study, and Act sections will be submitted during a time period to be specified in the future based on the *baseline data* collected during 2012. Note that MAOs may submit other clinical *CCIPs* in addition to the *CCIP* topic required by CMS. MAOs have the discretion to specify the expected timeframe for these additional *CCIPs* depending on the topic selected, *interventions* involved, or other factors.

The Health Plan Management System (HPMS) *CCIP* Module serves as the means for MAOs to submit and report on their *CCIPs* to CMS. *CCIP* reports will serve as a summary of a full *CCIP*. The *CCIP* module allows MAOs to report on the *CCIP* throughout the entire life cycle of the *CCIP* as defined below:

- **Plan** (Chapter II) – describes the processes, specifications, and output objectives used to establish the *CCIP*;
- **Do** (Chapter III) - describes how the *CCIP* will be conducted, the progress of the implementation, and the data collection plan;
- **Study** (Chapter IV) – describes and analyzes findings against targets or goals and identifies trends over several *PDSA* cycles that can be utilized for the “Act” stage;
- **Act** (Chapter V) – summarizes *action plan(s)* based on findings, describes, in particular, the differences between the actual and planned results, and provides information regarding any changes based on actions performed to improve processes and outcomes, including a short description of actions performed.

The module also gives MAOs the ability to **Copy** *CCIP* sections from one plan to another, as long as certain conditions exist, and to **Upload** supporting documentation.

In addition, the **Gates** link is provided to the MAOs to access the latest *CCIP* submission window (open/close) timeframes.

This document provides an overview and technical instructions for accessing HPMS and navigating through the *CCIP* module. General information about the *CCIP* and QI program requirements can be found on the CMS Quality website at www.cms.gov/quality. Please note that words available in the Glossary have been italicized. Please also note that Screen Prints (or screens) contained in this User's Manual are not intended to display complete functionality and are for demonstration purposes only.

NOTE: The HPMS screenshots in this User Guide refer to the CY 2011 CCIP module; however, please note that these screenshots are also applicable to the CY 2012 CCIP module.

I. GETTING STARTED

ACCESSING HPMS

The HPMS/CCIP Module is hosted on a secure extranet site that users can access via the Internet using a Secure Sockets Layer (SSL) Virtual Private Network (VPN). Users can also access the HPMS/CCIP Module by dial-up or CMSNet.

HPMS URLs:

- For the CMS SSL VPN portal: <https://gateway.cms.hhs.gov>.
- For CMSNet: <https://hpms.cms.gov/>

Contact the system administrator to access the CMSNet if the connection is not available.

CMS USER IDS

Users must have a CMS-issued User ID and password with HPMS access in order to log into the system. Users will also need to associate their User ID with the contract numbers that they will work with in HPMS.

To obtain a new CMS User ID, users must complete a CMS User ID request form, which can be downloaded and printed from:

<http://www.cms.gov/InformationSecurity/Downloads/EUAaccessform.pdf>.

This form includes a location for applicants to list the contract numbers to be associated with the requested User ID. Completed CMS User ID forms must be submitted to CMS at the following address:

CMS
Attn: Lori Robinson
7500 Security Boulevard
Mailstop C4-18-13
Baltimore, MD 21244-1850

If existing HPMS users need to associate a contract number to their current CMS User ID, please include the following information in an email to hpms_access@cms.hhs.gov:

- User Name,
- CMS User ID,
- Current Contract Number(s), and
- Contract Number(s) to be added.

All questions related to HPMS user access should be directed to hpms_access@cms.hhs.gov.

HOW TO ACCESS THE HPMS HOME PAGE USING THE INTERNET

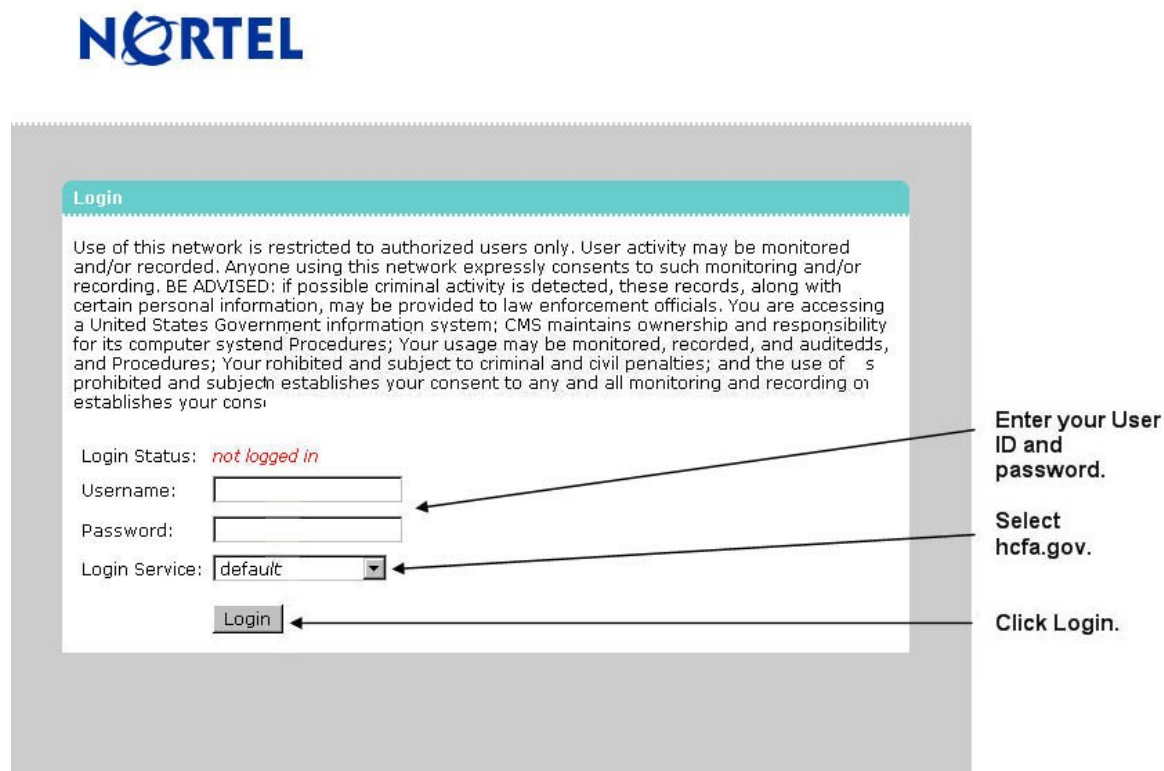
STEP 1

Open the web browser (e.g., Internet Explorer) and enter the CMS SSL VPN gateway address <https://gateway.cms.hhs.gov> in the Address field.

STEP 2

Enter the CMS User ID and password and select “hcfa.gov” as the login service. Click **Login** (Table I-1).

Table I-1



The screenshot shows the Nortel login interface. At the top left is the Nortel logo. Below it is a teal header with the word "Login". A paragraph of legal disclaimer text follows. Below the text, the login status is "not logged in". There are three input fields: "Username:", "Password:", and "Login Service:". The "Login Service" dropdown menu is currently set to "default". A "Login" button is at the bottom. Three arrows point from text annotations on the right to the Username field, the Login Service dropdown, and the Login button.

Enter your User ID and password.

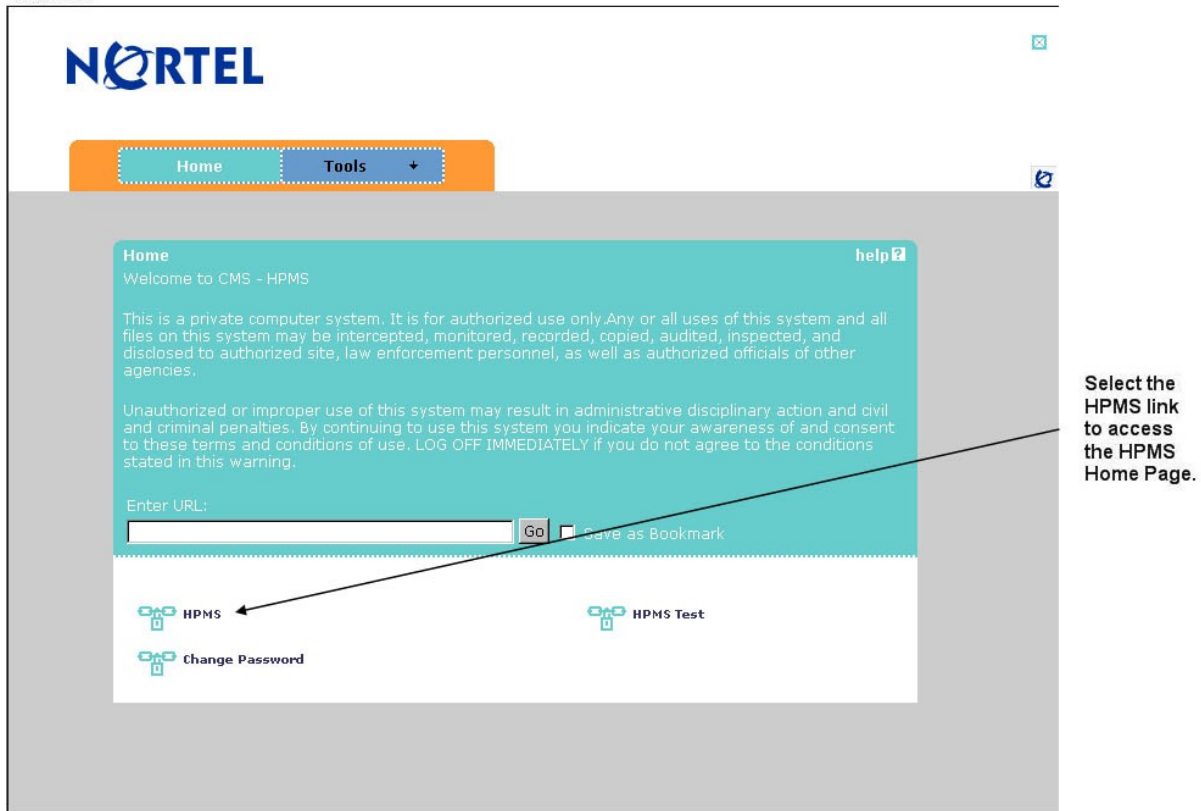
Select hcfa.gov.

Click Login.

STEP 3

Select the **HPMS** link from the SSL VPN portal screen to access the **HPMS Home** screen (Table I-2).

Table I-2



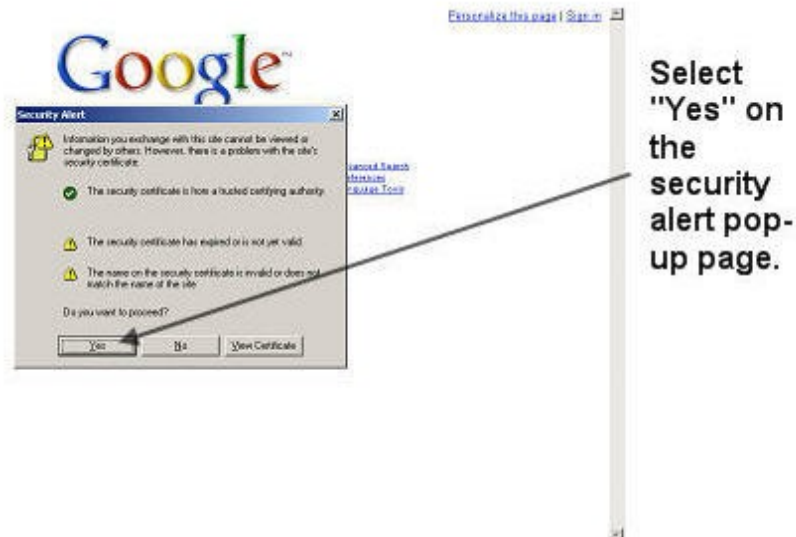
HOW TO ACCESS THE HPMS HOME PAGE USING THE CMSNET

STEP 1

Open the web browser (e.g., Internet Explorer) and enter the CMSNet address <https://hpms.cms.gov> in the Address field.

Select **Yes** on the **Security Alert** pop-up window (Table I-3).

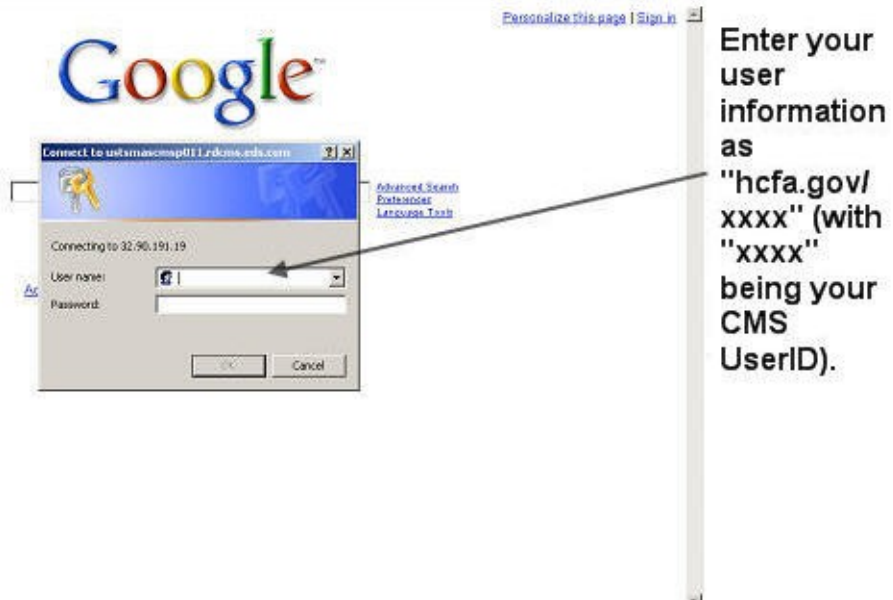
Table I-3



STEP 2

Enter the User Name as hcfa.gov/xxxx – where “xxxx” is the 4-digit CMS User ID. Enter the password and select **OK** (Table I-4) to access the **HPMS Home** screen.

Table I-4



STEP 3

Select the **HPMS** link from the SSL VPN portal page to access the **HPMS Home** screen (Table I-2).

HOW TO ACCESS THE HPMS PLAN REPORTING MODULE

All information requested as part of the HPMS *CCIP* module must be completed unless otherwise noted.

STEP 1

Select **Quality and Performance** on the Left Navigation Bar then select **CCIP** on the fly-out menu (Table I-5) to get to the **CCIP Contract Year** selection screen (Table I-6).

Table I-5

The screenshot shows the HPMS (Health Plan Management System) interface. At the top, there is a red header with 'HPMS' on the left and 'Health Plan Management System' on the right, with a 'Home' link. Below the header is a dark blue navigation bar with a 'Hello !' message. The main content area features a large warning message: 'This is a Warning! This is a test site, not the official HPMS Production site.' A fly-out menu is open over the 'Quality and Performance' link in the left navigation bar, showing options: 'Part D Performance Metrics and Reports', 'Part C Performance Metrics', 'CCIP' (highlighted in red), 'QIP', and 'Plan Reporting'. Below the warning, there is a link: 'Click here for the archived in the News items.' At the bottom of the page, there are several links: 'Website Accessibility', 'Web Policies', 'File Formats and Plug-Ins', 'Rules Of Behavior', and 'System Requirements'. The left navigation bar also includes a 'Log Off HPMS' button, a disclaimer: 'This is a U.S. Government computer system subject to Federal law.', and 'Top of Page' and 'Back' links.

STEP 2

Select the contract year in the **CCIP Contract Year** selection screen (see Table I-6) to get to the **CCIP Start Page** screen (Table I-7).



Table I-6		
	Health Plan Management System Home	
<div style="background-color: #cc0000; color: white; padding: 2px; text-align: center; margin-bottom: 10px;"> Contract Year 2011 </div> <div style="text-align: right; margin-top: 200px;"> Top of Page Back </div>	<h2 style="margin: 0;">CCIP Functionality</h2> <p>You have access to the following CCIP functionality in HPMS:</p> <p>Contract Year 2011 - To perform a Contract Year 2011 CCIP Submission, select the "Contract Year 2011" link.</p>	

Table I-7		
	Health Plan Management System Home	
<div style="text-align: right; margin-top: 10px;"> Top of Page Back </div>	<h2 style="margin: 0;">CY 2011 CCIP Start Page</h2> <p>In this module each of the following four Enter/Edit sections must be completed in the sequence listed below. You will use this module to perform the following:</p> <p>Gates - Enter/Edit Submission Period Start and End date information.</p> <p>Plan - Enter/Edit the Plan Section Information.</p> <p>Do - Enter/Edit the Do Section Information.</p> <p>Study - Enter/Edit the Study Section Information.</p> <p>Act - Enter/Edit the Act Section Information.</p> <p>Copy - Copy a section.</p> <p>Upload - Upload supporting documentation.</p> <p>User Guide - Access and View the User Guide for CY 2011.</p> <p>Instructions - Access and View the Instructions for CY 2011.</p> <hr/> <p>Go To: HPMS Home</p>	

GATE

The GATES link (Table I-8) allows users to view the latest *CCIP* Submission window (gate open/closed) information.

STEP 1

On the **CCIP Start Page** (Table I-7) click on the **Gates** link on the Left Navigation Bar to get to the **CY 2011 CCIP - Gates** screen (Table I-8). Note that on the sample screen in Table I-8, all components of the *CCIP* cycle are indicated to be open for submittal during the dates shown.

Table I-8

HPMS Home

CY 2011 CCIP - Gates Closed

The following dates are the valid Enter/Edit/Submission periods:

Start Date	End Date	Plan	Do	Study	Act
4/1/2012	5/15/2012	X	X	X	X

[Go To: CCIP Start Page](#)

II. PLAN

The **PLAN** functionality allows users to describe the *CCIP* and outline the expectations, basic approach, and *intervention(s)* that the user will further describe in the Do, Study, and Act sections. The 'PLAN Section' demonstrates an improvement opportunity (i.e. target goal), identifies what change(s) will be introduced (i.e. *intervention*), who will be involved (i.e. *target audience*), and the expected results (i.e. anticipated outcomes).

Please note the following information:

- If the user is submitting a CY 2012 *CCIP*, only the 'PLAN Section' will be available to fill out at this time. A CY 2012 *CCIP* submission will be complete once the 'PLAN Section' has been completed since this is a new submission.
- For CY 2012 *CCIP* submissions, the user will not be able to edit the 'PLAN Section' once it has been approved by the respective CMS account manager.
- The user will be unable to select a *CCIP* topic from the 'DO Section,' 'Study Section,' and 'ACT Section,' if the 'PLAN Section' has not been completed. This is because topics that appear are aligned with those that are established by the user in the 'PLAN Section.'

STEP 1

As shown in Table II-1, on the **CCIP Start Page** click on the **Plan** link on the Left Navigation Bar to get to the **Contract/Plan/Topic Selection** screen. (See Chapter I: Getting Started for help getting to the **CCIP Start Page**.)

Table II-1

HPMS Health Plan Management System [Home](#)

CY 2011 CCIP Start Page

In this module each of the following four Enter/Edit sections must be completed in the sequence listed below. You will use this module to perform the following:

Gates - Enter/Edit Submission Period Start and End date information.

Plan - Enter/Edit the Plan Section Information.

Do - Enter/Edit the Do Section Information.

Study - Enter/Edit the Study Section Information.

Act - Enter/Edit the Act Section Information.

Copy - Copy a section.

Upload - Upload supporting documentation.

User Guide - Access and View the User Guide for CY 2011.

Instructions - Access and View the Instructions for CY 2011.

Go To: [HPMS Home](#)

Enter/Edit
 Gates
Plan
 Do
 Study
 Act
 Copy
 Upload
Documentation
 Instructions
 User Guide

Top of Page
 Back

STEP 2

On the **Contract/Plan/Topic Selection** screen (Table II-2) first select a contract. Once the contract is selected, the screen will automatically refresh to show available plans. Users must create a unique *CCIP* for each *SNP* offered under a contract based on the *SNP's target population*. The *SNPs* are identified by their plan number. However, users may create the same *CCIP* for all of the non-*SNP* coordinated care plans offered under a contract. The non-*SNP* coordinated care plans under each contract are identified as 'Non-*SNP*'.

Once a plan is selected, the screen will again automatically refresh to show the *CCIP* topics. Either select an existing topic or select "Create a New Topic" and then click **Next**, which will take the user to the **MAO Information** screen (Table II-3).

Table II-2

HPMS Home

CY 2011 CCIP - Submission

PLAN Section – Contract/Plan/Topic Selection

Select a Contract:

- Z0001
- Z0002

Select a Plan:

- 006
- 007
- 009
- Non-SNP

Select a CCIP Topic:

- Create a New Topic

[Go To: CCIP Start Page](#)

STEP 3

The **MAO Information** screen (Table II-3) will default to MAO information that was already entered in HPMS for that particular plan. Provide all information related to the *CCIP* title, time length, and summary.

The MAO information should include contact information, plan type, and *program cycle year*. Provide the contract number (H#####, R#####, S#####) and the provider benefit package (PBP) identification number.

Provide information for the *CCIP* initial plan approval submission. If this is a new *CCIP*, select “Yes” and provide the length of time intended for the *CCIP*. If this is an ongoing *CCIP*, select “No” and provide the subsequent year report number.

The *CCIP* (including *PDSA* Sections) represents one full *program cycle year*. Select the *CCIP program cycle year* for this *CCIP* from the drop down list. The initial year the *CCIP* is implemented is year one. Year two is the second year of the *CCIP*.

The title of the *CCIP* must be unique for each *CCIP*.

Provide the *CCIP* title (Character Limit: 100) and a brief summary of the *CCIP*, which must include the specific clinical foci and the expected outcomes of the *CCIP* (Character Limit: 1,000). A *CCIP* is a clinical program focused on improving the health of a population with chronic condition(s). Once diagnosed, chronic conditions require ongoing management to prevent and control exacerbations and prevent other related conditions from developing.

Note: If the information on the Quality Contact Person or the Compliance Contact Person is incorrect, the MAO must edit that contact information using the Set-Up Plans function in HPMS. Instructions on how to update contact information is contained in the *Bid Submissions User's Manual*.

Click **Next** to get to the **PLAN Section (A)** screen.

CY 2011 CCIP - Submission

Plan Section - MAO Information

Medicare Advantage Organization (MAO) Information

Chronic Care Improvement Program (CCIP): A program to manage chronic conditions by preventing and or minimizing the effects of the condition through patient self-management and integrated care in order to improve health outcomes and decrease costs.

MAO Name: EXAMPLE CONTRACT 1

Contract Number: 20001

Identification Number: 009

MAO: 123 Elm Street

Location: Arlington, VA 22201

Quality Contact Person

Name: John Test

Title: Quality Enhancement Analyst

Telephone: 800-292-8868

Email: test@test.com

Compliance Contact Person

Name: John Test

Title: Chief Financial Officer

Telephone: 800-292-8868

Email: test@test.com

MAO Plan Type: Local CCP

CCIP Initial Plan Approval Submission:

Yes

State the length of time intended for the program:

N/A

Subsequent Year Report #:

Select a Subsequent Year

Title:

Coronary Artery Disease (CAD)

Provide a brief summary of the CCIP to include the specific clinical foci and expected outcomes:

The CCIP will focus on patient self-management through education combined with intensive Registered Nurse (RN) case management (CM) to achieve the goal of slowing CAD progression and optimizing the quality of life among the members enrolled in the program.

[Go To: CCIP Start Page](#)

STEP 4

On the **PLAN Section (A)** screen (Table II-4) enter information about the basis for selection, including all data sources.

A1. Disease State

(Character Limit: 100)

For “A1. Disease State,” provide the disease state(s) or chronic condition(s) for this *CCIP* along with the ICD-9-CM code(s). Selection of the ICD-9-CM code(s) must be specific. Once the MAO enters a disease state in this field, the disease state will auto-populate in other relevant fields throughout the tool.

A2. Rationale for Selection

(Character Limit: 4,000)

For “A2. Rationale for Selection,” provide a detailed and in depth description that includes: 1) the rationale for selecting the specific disease or condition; 2) how the information gathered from the data sources showed a gap in care which supports the need for a *CCIP*; 3) the incidence and/or prevalence of the disease or condition within the MA plan’s *target population*; and 4) the source data.

A3. Relevance to the Plan Population

(Character Limit: 4,000)

For “A3. Relevance to the Plan Population,” provide a detailed and in depth description that is consistent with the overall goal of the *CCIP* and reflects the needs of the *target population*. The description must include: 1) how the *CCIP* is relevant to the MA plan’s *target population* by describing the incidence and/or prevalence of the disease; 2) the current disease impact on the MA plan members; and 3) how filling the gap in care identified in “A2. Rationale for Selection” will improve health outcomes.

A4. Anticipated Outcomes

(Character Limit: 4,000)

For “A4. Anticipated Outcomes,” provide a detailed and in depth description of the anticipated outcomes. The description must be consistent with the overall goal of the *CCIP* and include: 1) how the *CCIP* relates to the responses in “A2. Rationale for Selection” and “A3. Relevance to the Plan Population;” 2) what the MA plan expects the *CCIP* to achieve; 3) how the *target population* will be impacted by the outcomes; 4) a description of the evidence-based guidelines considered; and 5) how these guidelines will be effective in producing improved health outcomes.

A5. Data Source(s) for Selected Chronic Condition

For “A5. Data Source(s) for Selected Chronic Condition,” the plan must check all of the data sources that were used to identify and support the disease state or chronic condition. If selecting “Other Sources,” please describe in the text field. A plan may select up to five other sources.

Click **Next** to get to the **PLAN Section (B1)** screen.

CY 2011 CCIP - Submission

Enter/Edit - PLAN Section (A)

MAO Name: EXAMPLE CONTRACT 1

Contract Number: Z0001

Identification Number: 009

Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)

A. Basis for Selection

A1. Disease

State:

Coronary Artery Disease 410.0 - 414.2, 414.8

ICD-9 Code(s)

A2. Rationale for Selection:

A comprehensive claims review revealed that there was increased utilization of medical services, including hospital inpatient admissions and readmissions, Emergency Department (ED) visits, surgical interventions, and physician visits within CAD population. In our plan, 60% of our members have a diagnosis of CAD.

A3. Relevance to the Plan Population:

There is a high prevalence of CAD within our plan population. Of our 1000 members, 600 members have a diagnosis of CAD. The CCIP will initially be targeting all individuals with a high acuity level.

A4. Anticipated Outcomes:

Focusing on medication adherence, modification of risk factors and use of appropriate clinical practice guidelines has proven to effect slowing progression of CAD and as a result will positively impact the utilization of medical and surgical services.

A5. Data Source(s) for Selected Chronic Condition (Check all that apply)

<input checked="" type="checkbox"/> Medical Records	<input type="checkbox"/> MAO Part C Reporting Requirements
<input checked="" type="checkbox"/> Claims (Medical, Pharmacy, Laboratory)	<input checked="" type="checkbox"/> Encounter Data
<input type="checkbox"/> Appointment Data	<input type="checkbox"/> Audit Findings
<input type="checkbox"/> Plan Data (complaints, appeals, customer service)	<input type="checkbox"/> Health Effectiveness Data Information Set (HEDIS®)
<input checked="" type="checkbox"/> Health Risk Assessment (HRA) Tools	<input type="checkbox"/> Health Outcomes Survey (HOS)
<input type="checkbox"/> Surveys (enrollee, beneficiary satisfaction, other)	<input type="checkbox"/> Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
<input type="checkbox"/> Minimum Data Set (MDS) - Institutional SNP	<input type="checkbox"/> Registries
<input type="checkbox"/> Other Sources	<input type="checkbox"/> Other Sources
<input type="checkbox"/> Other Sources	<input type="checkbox"/> Other Sources
<input type="checkbox"/> Other Sources	

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Go To: [CCIP Start Page](#)

STEP 5

On the **PLAN Section (B1)** screen (Table II-5) use the form displayed on the screen to describe the program design.

B1. Population Identification Process

The population identification process involves identifying members with a disease state who would benefit from *disease management*. This process is based on review of member demographic characteristics, previous healthcare use, and healthcare expenditures.

B1a. Describe the *Target Population*

(Character Limit: 1,000)

For “B1a. Describe the *Target Population*,” provide a detailed and in depth description that is consistent with the overall goal of the *CCIP* and includes: 1) the *inclusion and exclusion criteria* being used; 2) the rate of incidence among the members related to the *inclusion criteria*; 3) the severity of disease level of the members included; and 4) the demographics and clinical variable(s) used to identify those appropriate for *inclusion* into the *CCIP*.

B1b. Method of Identifying Members

For “B1b. Method of Identifying Members,” select all applicable methods that were used to identify the members for *inclusion* in the *CCIP*. If “Other” is selected, enter a description in the text field. Up to four additional methods may be added.

B1c. Risk Stratification

For “B1c. Risk Stratification,” select all applicable severity level(s) of the members the *CCIP* will target (i.e. High, Medium or Low).

B1d. Enrollment Method

For “B1d. Enrollment Method,” select the one method that will be used to enroll members into the *CCIP* (i.e. Opt in or Opt out).

Click **Next** to get to the **PLAN Section (B2, B3)** screen.

CY 2011 CCIP - Submission

Enter/Edit - PLAN Section (B1)

MAO Name: EXAMPLE CONTRACT 1

Contract Number: Z0001

Identification Number: 009

Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)

B. Program Design

B1. Population Identification Process:

B1a. Describe the Target Population:

Inclusion Criteria: Members 18 years of age or older with a diagnosis of CAD with a high acuity level which puts them at increased risk for disease progression, MI or heart failure. For the purpose of the CCIP, high acuity level is defined as members with a 20% or greater 10-year risk for Hard Coronary Heart Disease (HCHD) (e.g. myocardial infarction or coronary death) determined by a HCHD Framingham Score of 15 or higher (for men) or 23 or higher (for women).

B1b. Method of identifying members: (Check all that apply)

<input checked="" type="checkbox"/> Health risk assessment	<input checked="" type="checkbox"/> Utilization Management Data
<input checked="" type="checkbox"/> Claims Data (Medical, Pharmacy, Laboratory)	<input checked="" type="checkbox"/> Case Management Referrals
<input checked="" type="checkbox"/> Encounter Data	<input type="checkbox"/> Surveys
<input checked="" type="checkbox"/> Enrollment Data	<input type="checkbox"/> Registry
<input type="checkbox"/> Other <input type="text"/>	<input type="checkbox"/> Other <input type="text"/>
<input type="checkbox"/> Other <input type="text"/>	<input type="checkbox"/> Other <input type="text"/>
<input type="checkbox"/> Other <input type="text"/>	

B1c. Risk Stratification: (patient acuity level)

- High
 Medium
 Low

B1d. Enrollment Method:

- Opt in
 Opt out

Opt in - Member must ask for inclusion in program.

Opt out - Member automatically included in program and must ask to be excluded.

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Go To: [CCIP Start Page](#)

STEP 6

On the **PLAN Section (B2, B3)** screen (Table II-6) use the form displayed on the screen to describe any evidence based information and the care coordination approach.

B2. Evidence-Based Medicine

(Character Limit: 4,000)

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 *CCIP* and includes: 1) the evidence-based medical guideline(s) chosen from a credible and authoritative source; 2) why the guideline(s) was chosen including how using it will impact health outcomes; 3) how the guideline(s) will be applied to the *CCIP* across different demographics and severity of disease levels with an example provided; and 4) the source and date of the guideline(s).

B3. Care Coordination Approach

(Character Limit: 4,000)

The care coordination approach, or collaborative care model, consists of a multidisciplinary team that may include physicians, pharmacists, nurses, dieticians, and psychologists. Patient-centered, collaborative care is the foundation of this practice-based model in which the formation of patient/provider partnerships and community/healthcare system partnerships is essential for improved outcomes. The collaborative care model is the instrument by which self-management support is delivered.

For “B3. Care Coordination Approach,” provide a detailed and in depth description that is consistent with the overall goal of the *CCIP* and includes: 1) the components and organization of the care coordination team which includes both internal and external team members; 2) the team’s approach for the *CCIP*; 3) the roles and responsibilities of the team members; 4) how the team will communicate and work together to support the members and the goal of the *CCIP*, with an example provided; and 5) how the individual member’s goals and outcomes will be assessed and addressed with an example provided (e.g., staff and resources utilized, and the type of communication being used among team members).

Click **Next** to get to the **PLAN Section (B4)** screen.

CY 2011 CCIP - Submission

Enter/Edit - PLAN Section (B2, B3)

MAO Name: EXAMPLE CONTRACT 1

Contract Number: Z0001

Identification Number: 009

Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)

B2. Evidence Based Medicine:

(Provide current clinical practice guidelines and evidence-based treatment modalities, standards of care, evidence-based best practices, etc.)

The CCIP will apply a multi-pronged approach for improving health outcomes for members who have been stratified as high acuity level. The first approach will be educating members on pharmacologic interventions and compliance with those medications; this includes long term treatment as well as treatment for emergent symptoms.

B3. Care Coordination Approach:

(Describe the model, e.g., integration, collaboration, community resources, and communication among team members including provider, patient, and CCIP team members.)

The multidisciplinary team consists of Registered Nurse (RN) case managers (CM), clinical pharmacists, Registered Dietitians (RD), and a Cardiologist serving as Medical Director.

Many of the plan members have at least one co-morbid condition; the CCIP will be one of a holistic model in order to provide optimal care and management to the member. Due to the high acuity of the members we will provide an intensive disease management program.

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Go To: [CCIP Start Page](#)

STEP 7

On the **PLAN Section (B4)** screen (Table II-7) select the type of education. The screen will then refresh to allow the user to enter information based on the type of education selected. Use the form displayed on the screen to describe the method and the topics covered.

B4. Education

Patient and/or provider education is an integral part of the *CCIP*. Patient education focuses on the provision of education and supportive *interventions* to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem solving support. Empowering patients through education to more effectively "self-manage" is paramount to improved health outcomes. Provider education focuses on the provision of the most up to date evidence-based medical guidelines for the treatment of the disease state or condition that the *CCIP* is targeting.

The education component may be focused on the patients, the providers, or both. Indicate if the education is patient focused, provider focused, or a combination of both by selecting the

appropriate option. The applicable tables will then be available for completion. When selecting the Patient Self-Management option, two tables will appear.

“B4a. Patient Self-Management,” focuses on the education that the MAO will provide relating to the disease state or condition of the *CCIP*.

“B4a-1. Patient Self-Management–Other *Comorbid Conditions*” focuses on other conditions that may affect members enrolled in the *CCIP*. This section is optional and only needs to be completed if applicable. This section may be repeated up to five times, as needed, for additional *comorbid conditions*.

B4a. Patient Self-Management

(Character Limit: 4,000)

For “B4a. Patient Self-Management” education, if applicable, provides a detailed and in depth description that is consistent with the overall goal of the *CCIP* and includes the planned methods and the educational topics that will be used for training, support, monitoring, and follow-up of the members. The description must include: 1) methods that are varied and take into consideration the different demographics, socioeconomic status, and cultural backgrounds of the members; 2) educational topics that support improvement in health outcomes and are designed for various severity of disease levels, demographics, socioeconomic status, and cultural backgrounds of the members; and 3) training, support, monitoring, and follow-up.

B4a-1. Patient Self-Management–Other *Comorbid Conditions*

(Character Limit: 4,000)

For “B4a-1. Patient Self-Management–Other *Comorbid Conditions*” education, if applicable, provide a detailed and in depth description that is consistent with the overall goal of the *CCIP* and includes planned methods and educational topics that will be used for training, support, monitoring, and follow-up of the members. The description must include: 1) methods that are varied and take into consideration the different demographics, socioeconomic status, and cultural backgrounds of the MA plan members; 2) educational topics that support improvement in health outcomes and are designed for different severity of disease levels, demographics, socioeconomic status, and cultural backgrounds of the members; and 3) training, support, monitoring, and follow-up.

B4b. Provider Education

In “B4b. Provider Education,” a text box appears above the table to indicate the type of provider on which the education will focus.

(Character Limit: 50)

For “B4b. Provider Education,” if applicable, provide a detailed and in depth description that is consistent with the overall goal of the *CCIP* and provides specific details concerning the planned methods and educational topics that will be used for training, support, monitoring, and follow-up of the providers. The description must include: 1) provider training of the applicable evidence-based guidelines and practice patterns for the identified disease state or condition; 2) the methods for providing appropriate support for the members in managing their condition and monitoring the member; and 3) the methods and frequency for follow-up of the member.

(Character Limit: 4,000)

Note:

- The *CCIP* module defaults to one *intervention* in this section. If necessary, the user can add more *interventions* by clicking **Add** near the bottom of the screen. Also, if additional *interventions* already exist for the *CCIP*, the user can delete an *intervention* by clicking **Delete**.
- If the *CCIP* already includes more than one *intervention*, then upon clicking **Next** the user will go to the **Plan Section (B4)** screen for the second *intervention*. Continue entering all information and click **Next** as appropriate until information has been entered for all *interventions*. After entering all information, the user will proceed to the **PLAN Section (B5)** screen.

After entering all information for all *interventions*, click **Next** to get to the **PLAN Section (B5)** screen.

CY 2011 CCIP - Submission

Enter/Edit - PLAN Section (B4)

MAO Name: EXAMPLE CONTRACT 1
Contract Number: Z0001
Identification Number: 009
Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)

B4. Education:

(Select the type of education and then describe the method of education and the topics covered e.g., diabetes, COPD.)

- Type of Education:**
- Patient Self Management
 - Provider Education
 - Both

B4a. Patient Self management (Entry #1)	
Disease Management: Coronary Artery Disease 410.0 - 414.2, 414.8	
Method	Topics Covered
Training: Phone calls Web Portal Community Resources: American Heart Association, American Lung Association, American Diabetes Association, Weight Watchers	Training: CAD Risk Assessment: Assess and reassess the individual member's HCHD Framingham Score and their high risk for disease progression
Support: Plan RN Case Manager phone calls Web Portals	Support: Reinforcement of topics covered in training. Arrange for medications to be home delivered as appropriate.
Monitoring: Plan RN Case Manager phone calls	Monitoring: Lab values (e.g. LDL, HDL, HgA1c), weight, blood pressure, signs and symptoms of CAD progression, hospitalizations, ED visits, and surgical procedures
Follow-up: Phone calls Mailings	Follow-up: Reinforcement of lifestyle modifications and adherence to medication regimen RN CM will discuss the achievement of health quality goals with the member on a monthly basis.
Other: Member Satisfaction Survey	Other: A survey to evaluate the member satisfaction with the program will be sent to each member on a quarterly basis.

B4b. Provider Education (Entry #1)	
Provider Education: Not identified	
Method	Topics Covered
Training: Accredited educational program Mail	Training: The Medical Director will present an accredited CE program to discuss the current clinical practice guidelines.
Support: Provider relations	Support: Provider relations will contact PCPs with program updates, encourage providers to contact with comments, questions, suggestions, etc.
Monitoring: Adherence to clinical practice guidelines	Monitoring: Clinical pharmacists will provide monthly DUR and NTH reports to ensure adherence to the clinical practice guidelines.
Follow-up: Plan RN Case Manager phone calls	Follow-up: The RN CM will follow-up with the member's PCPs after each appointment to identify any changes that were made to their medication regimen and/or if their health status changed.
Other: Survey	Other: A survey to evaluate the satisfaction with the program will be sent to each provider on a quarterly basis.

To enter additional Education, please select the 'Add' button.

Add

Previous Next

STEP 8

On the **PLAN Section (B5)** screen (Table II-8) use the form displayed on the screen to describe any the outcomes measures and *interventions*.

B5: Outcomes Measures and Interventions

Outcome measures are used to identify how well the *CCIP* is working and the final product or end result. This measurement determines if the *CCIP* is stable and if the processes that led to the outcome are functioning effectively and efficiently. Outcome measurement reflects the impact the *CCIP* and *interventions* had on the health status of the targeted population. Outcome measures involve setting objectives in measureable terms, identifying the appropriate data source(s) to measure, and the *methodology* used to analyze the data.

The Outcome Measures and *Interventions* table may be repeated a total of three times in order to identify more than one *intervention*.

B5a. Goal

(Character Limit: 500)

The user should select only one goal for the *CCIP* regardless of the number of *interventions* it implements. All *interventions* should work towards achieving the same goal. Users can enter up to three *interventions* in B5d for their stated goal (i.e., the description the user has provided in “B5a. Goal”). In sections where *intervention(s)* auto-populate, each *intervention* will be carried through. (Note: Users cannot edit text that has been auto-populated from a different section.)

For “B5a. Goal,” provide a detailed and in depth description that is consistent with “Section A. Basis for Selection,” and includes: 1) a goal that is specific and relevant to the disease state or condition and the program; 2) the evidence or factors considered that show how the goal will impact health outcomes; and 3) how the goal is measureable and attainable within the established timeframe.

B5b: Benchmark

(Character Limit: 500)

Plans will compare the results of their *interventions* to *benchmark* data in order to measure the effectiveness of their *interventions* at the end of the reporting cycle.

For “B5b. *Benchmark*,” provide a detailed, in depth description that is consistent with the goal of the *CCIP* and includes: 1) a valid, reliable performance standard that is relevant to the goal of the *CCIP*; 2) how the *benchmark* relates to the demographics of the *target population*; 3) how the *benchmark* reflects the severity of the targeted disease state or condition; 4) reliable source(s); and 5) the date that the *benchmark* was measured/established.

B5c: Check Boxes for Goal and Benchmark

For “B5c. Check Boxes for Goal and *Benchmark*,” select how the goal will impact the MA population by marking all that apply. If Other is selected, provide a description in the text field. Select whether the *benchmark* is *baseline*, *internal* or *external* as defined below:

- **Baseline Benchmark**

Select *baseline benchmark* if the data was obtained at the end of the current reporting cycle as the standard of comparison for subsequent reporting cycles. *Baseline benchmark* is the first measure used as a point of reference in which a *CCIP* can be measured, compared, or judged.

- **Internal Benchmark**

Select *internal benchmark* if the data used is from the plan’s own data sources (e.g., administrative data or claims data) for comparison.

- **External Benchmark**

Select *external benchmark* if the data was 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 *CCIP*.

B5d. Intervention

(Character Limit: 4,000)

For “B5d. *Intervention*,” provide a detailed and in depth description that reflects the strategy that will be used to improve health outcomes and includes: 1) an explanation of the *intervention* being used; 2) how the *intervention* is measureable and capable of improving health outcomes; 3) how the *intervention* relates to the goal; and 4) how the *intervention* is sustainable over time.

B5e. Rationale for Specific Intervention Related to Goal or Benchmark

(Character Limit: 4,000)

For “B5e. Rationale for specific *intervention* related to goal or *benchmark*,” provide a detailed and in depth description of the process used in developing the *intervention* and includes: 1) the reason the *intervention* was chosen; 2) how the *intervention* relates to the goal and *benchmark*; 3) the factors or evidence considered when developing the *intervention* that demonstrates its validity; and 4) the anticipated impact on health outcome(s).

B5f. Measurement Methodology

(Character Limit: 4,000)

Measurement *methodology* is the means, technique, procedure, or method used to collect data and measure the effectiveness of the *CCIP* or *intervention*. Users should describe the *methodology* they will use for each unique *intervention* they plan to implement.

For “B5f. *Measurement Methodology*,” provide a detailed and in depth description that includes: 1) the specific valid and reliable data that will be collected for measurement; 2) a description of how the measure relates to the *intervention*, the goal, and the *benchmark* included in “B5b. *Benchmark*;” 3) the systematic method in which the data will be collected; and 4) the frequency of data collection and *analysis*.

B5g. Timeline

(Character Limit: 1,000)

For “B5g. *Timeline*,” provide a detailed and in depth description that must be consistent with the overall goal of the *CCIP* and includes: 1) exact beginning and ending dates from implementation to the completion of the measurement cycle; 2) an explanation of how the timeline reflects an appropriate amount of time to complete the planned *intervention*; and, 3) the rationale for the

expected timeline. MAOs should ensure that the listed timelines are specific to each *intervention* and fit within the *CCIP program cycle*.

Note:

- The *CCIP* module defaults to one *intervention* in this section. If necessary, the user can add more *interventions* by clicking **Add** near the bottom of the screen. Also, if additional *interventions* already exist for the *CCIP*, the user can delete an *intervention* by clicking **Delete**.
- If the *CCIP* already includes more than one *intervention*, then upon clicking **Next** the user will go to the **Plan Section (B5)** screen for the second *intervention*. Continue entering all information and clicking **Next** as appropriate until information has been entered for all *interventions*. After entering all information, the user will proceed to the **PLAN Section (B6)** screen.

After entering all information for all *interventions*, click **Next** to get to the **PLAN Section (B6)** screen.

CY 2011 CCIP - Submission

Enter/Edit - PLAN Section (B5)

MAO Name: EXAMPLE CONTRACT 1

Contract Number: Z0001

Identification Number: 009

Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)

<p>B5. Outcome Measures and Interventions: (Entry #1)</p> <p>B5a. Goal: The goal is to increase medication adherence, provide support in the achievement of health quality goals, and expand the application of the current clinical practice guidelines thereby delaying the</p> <p>B5b. Benchmark: The following plan data is the internal benchmark being used: (12 months medical, surgical and pharmacy claims, and UM data per the 100 high risk members).</p> <p>B5c. Goal: <input checked="" type="radio"/> Clinical <input type="radio"/> Utilization Access <input type="radio"/> Satisfaction Survey <input type="radio"/> Other <input type="text"/> Benchmark: <input type="radio"/> Baseline <input checked="" type="radio"/> Internal <input type="radio"/> External</p> <p>B5d. Interventions: Along with the above described intensive disease management program and education we will provide the following: For the Member: Prefilled Medisets or Pill Organizers - Mailed out to the members. RN CM will educate on use and compliance.</p> <p>B5e. Rationale for specific intervention related to goal or benchmark: The CAD intervention was selected because when conducting the root-cause analysis of the issue it was discovered that our members were not refilling their medications at appropriate intervals and/or their pharmacotherapy regimen was not according to the most current clinical practice guidelines. The CM and education program will provide members with the needed follow up and knowledge to understand the rationale behind medication compliance.</p> <p>B5f. Measurement Methodology: Medical, surgical and pharmacy claims and UM data reports will be collected and analyzed quarterly.</p> <p>B5g. Timeline: 09.01.10 through 08.31.11</p>

To enter additional B5a - B5g information, please select the "Add" button.

Add

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STEP 9

On the **PLAN Section (B6)** screen (Table II-9) use the form displayed on the screen to describe the communication sources.

B6. Communication Sources including the Interdisciplinary Care Team and Patients

Communication sources are the methods used to inform patients, physicians, and ancillary providers on what is occurring in the *CCIP* and of any changes that might be made to the *CCIP*. It may also include communication with the health plan and practice profiling.

The appropriate options must be selected under “B6a. Sources” and “B6b. *Target Audience*.”

B6a. Sources

For “B6a. Sources,” select how the program will integrate continuous feedback among all parties involved in the program by marking all that apply. If selecting Other, please describe in the text field provided.

B6b. *Target Audience*

For “B6b. *Target Audience*,” select all parties involved in the program that will be integrated into the continuous feedback loop by marking all that apply. If selecting Other, please describe in the text field provided.

Note:

- The *CCIP* module defaults to one *intervention* in this section. If necessary, the user can add more *interventions* by clicking **Add** near the bottom of the screen. Also, if additional *interventions* already exist for the *CCIP*, the user can delete an *intervention* by clicking **Delete**.
- If the *CCIP* already includes more than one *intervention*, then upon clicking **Next** the user will go to the **Plan Section (B6)** screen for the second *intervention*. Continue entering all information and clicking **Next** as appropriate until information has been entered for all *interventions*.

After entering all information for all *interventions*, click **Next** to get to the **PLAN Section (C)** screen.

CY 2011 CCIP - Submission

Enter/Edit- PLAN Section (B6)

MAO Name: EXAMPLE CONTRACT 1

Contract Number: Z0001

Identification Number: 009

Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)

B6. Communication Sources including the Interdisciplinary Care Team and Patients:

(Describe how the program integrates continuous feedback among all parties.)

B6a. Sources <i>(Check all that apply)</i>	
<input checked="" type="checkbox"/> Electronic Communications (Website, portal, email, etc.)	<input checked="" type="checkbox"/> Surveys (Satisfaction Survey, Comment Cards, Complaint Tracking, etc.)
<input checked="" type="checkbox"/> Telecommunications (Phone calls, phone text messages, public media, etc.)	<input checked="" type="checkbox"/> Face-to-face Patient Education
<input checked="" type="checkbox"/> Written Materials (Brochures, provider newsletters, member newsletters, flyers, etc.)	<input type="checkbox"/> Other <input type="text"/>
<input type="checkbox"/> Other <input type="text"/>	<input type="checkbox"/> Other <input type="text"/>
<input type="checkbox"/> Other <input type="text"/>	<input type="checkbox"/> Other <input type="text"/>

B6b. Target Audience <i>(Check all that apply)</i>	
<input checked="" type="checkbox"/> Providers	<input checked="" type="checkbox"/> Case Manager
<input checked="" type="checkbox"/> Patients	<input checked="" type="checkbox"/> Care Team
<input checked="" type="checkbox"/> Family Members	<input type="checkbox"/> Educator
<input type="checkbox"/> Other <input type="text"/>	<input type="checkbox"/> Other <input type="text"/>
<input type="checkbox"/> Other <input type="text"/>	<input type="checkbox"/> Other <input type="text"/>
<input type="checkbox"/> Other <input type="text"/>	

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Go To: [CCIP Start Page](#)

STEP 10

On the **PLAN Section (C)** screen (Table II-10) use the form displayed on the screen to provide contact information for the MAO Medical Director, a person designated by the Medical Director, or other person of authority who is approving the *CCIP*. This section must be fully completed. Once the Medical Director or designee approves the *CCIP* submission and clicks **Next**, the user taken to the **Verification** screen (Table II-11).

CY 2011 CCIP - Submission

Enter/Edit - PLAN Section (C)

MAO Name: EXAMPLE CONTRACT 1

Contract Number: Z0001

Identification Number: 009

Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)

C. Plan Section Approval: (Medical Director)

This section needs to be completed by the MA plan's Medical Director, a person designated by the Medical Director, or other person of authority.

Name of Individual:	<input type="text" value="John Test"/>
Title:	<input type="text" value="Dr."/>
E-mail Address:	<input type="text" value="john.test@test.com"/>
Phone:	<input type="text" value="301-223-7825"/> (###-###-####) Ext. <input type="text" value="123"/>
Date of Approval:	<input type="text" value="05/15/2012"/> (MM/DD/YYYY)

[Go To: CCIP Start Page](#)

STEP 11

On the **Verification** screen (Table II-11) review all information for accuracy.

Once the user confirms that the information related to the **PLAN Section** is accurate, the user will select **Save**. Click **Previous** to return to the screens to edit any information. After clicking **Save** the user will be taken to the **PLAN Section Submission Confirmation** screen (Table II-12) that includes the following message: "Your data has been saved." Click **OK** to return to the **CCIP Start Page**.

Note: If this is the MAO's initial *CCIP* submission, the submission is complete at this step, as only the plan section is to be submitted for review by the MAO's respective CMS account manager.

Table B-11
HEPSES Home

CY 2011 CCIP - Submission

PLAN Section Verification

MAG Name: EXAMPLE CONTRACT 1
Contract Number: 20001
Identification Number: 000
MAG Location: 123 Elm Street
 Atglen, VA 22021

Quality Contact Person:
 Name: John Test
 Title: Quality Improvement Analyst
 Telephone: 800-252-8888
 Email: test@test.com

Compliance Contact Person:
 Name: John Test
 Title: Chief Financial Officer
 Telephone: 800-252-8888
 Email: test@test.com

MAG Plan Type: Local CCP

CCIP Initial Plan Approval Submission: Yes

State the length of time extended for the program: N/A

Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)

Summary of the CCP to include the specific clinical goal and expected outcomes:
 The CCP will focus on patient self-management through education combined with intensive Registered Nurse (RN) case management (CM) to achieve the goal of slowing CAD progression and improving the quality of life among the members enrolled in the program.

Your data has not yet been saved.

Medicare Advantage Organization (MAO) Information

A. Basis for Selection

A1. Disease State (ICD-9 code(s)): Coronary Artery Disease 410.0 - 414.2, 414.8

A2. Rationale for Selection: A comprehensive claims review revealed that there was increased utilization of medical services, including hospital inpatient admissions and readmissions, Emergency Department (ED) visits, surgical interventions, and physician visits within CAD population. In our plan, 60% of our members have a diagnosis of CAD.

A3. Relevance to the Risk Population: There is a high prevalence of CAD within our plan population. Of our 1000 members, 600 members have a diagnosis of CAD. The CCP will initially be targeting individuals with a high acuity level.

A4. Anticipated Outcomes: Focusing on medication adherence, modification of risk factors and use of appropriate clinical practice guidelines has proven to affect slowing progression of CAD and as a result will positively impact the utilization of medical and surgical services.

A5. Data Sources (1) for Selected Chronic Condition:
 Medical Records
 Claims Data (Medical, Pharmacy, Laboratory)
 Encounter Data
 Health Risk Assessment (HRA) Tools

B. Program Design

B1. Population Identification Process

B1a. Describe the Target Population: Inclusion Criteria: Members 18 years of age or older with a diagnosis of CAD with a high acuity level (high acuity level is defined as increased risk for disease progression, MI or heart failure. For the purpose of the CCP, high acuity level is defined as members with a 20% or greater 10-year risk for hard Coronary Heart Disease (CHD) (e.g. myocardial infarction or coronary death) determined by a HCHD Framingham Score of 15 or higher (for men) or 23 or higher (for women).

B1b. Method of Identifying Members: Health risk assessment
 Utilization Management Data
 Claims Data (Medical, Pharmacy, Laboratory)
 Case Management Behavior
 Encounter Data
 Enrollment Data

B1c. Risk Stratification (patient acuity level): High

B1d. Enrollment Method: Opt out

B2. Evidence Based Medicine

The CCP will apply a multi-pronged approach for improving health outcomes for members who have been stratified as high acuity level. The first approach will be educating members on pharmacologic, non-pharmacologic and compliance with their medications. This includes long term treatment as well as treatment for emergent symptoms.

B3. Care-Coordination Approach

The multidisciplinary team consists of Registered Nurse (RN) case managers (CM), clinical pharmacists, Registered Dietitians (RD), and a Cardiologist serving as Medical Director. Many of the plan members live in rural areas. For the purpose of the CCP, the use of a hybrid model in order to provide optimal care and management to the member. Due to the high acuity of the members we will provide an intensive disease management program.

B4. Education

Type of Education: Both

Patient Self Management Entry #1

Method Training: Phone calls Web Portal Community Resources: American Heart Association, American Lung Association, American Diabetes Association, Weight Watchers

Method Support: Plan RN Case Manager phone calls Web Portal

Method Monitoring: Plan RN Case Manager phone calls

Method Follow-up: Phone calls Mailings

Method Other: Member Satisfaction Survey

Topic Covered Training: CAD Risk Assessment: Assess and reassess the individual member's HCHD Framingham Score and their high risk for disease progression

Topic Covered Support: Reinforcement of topics covered in training. Arrange for medications to be home delivered as appropriate

Topic Covered Follow-up: Lab values (e.g. LDL, HDL, HgbA1c), weight, blood pressure, signs and symptoms of CAD progression, hyperlipidemia, ED visits, and surgical procedures

Topic Covered Other: Reinforcement of lifestyle modifications and adherence to medication regimen RN CM will discuss the achievement of health quality goals with the member on a monthly basis

Provider Education: Not identified

Provider Education Entry #1

Method Training: Accredited educational program held

Method Support: Provider relations

Method Monitoring: Adherence to clinical practice guidelines

Method Follow-up: Plan RN Case Manager phone calls

Method Other: Survey

Topic Covered Training: The Medical Director will present an accredited CE program to discuss the current clinical practice guidelines

Topic Covered Support: Provider relations will contact PCPs with program updates, encourage providers to contact with comments, questions, suggestions, etc.

Topic Covered Follow-up: The RN CM will follow-up with the member's PCP after each appointment to identify any changes that were made to their medication regimen and/or if their health status changed.

Topic Covered Other: A survey to evaluate the satisfaction with the program will be sent to each provider on a quarterly basis

Outcome Measures and Interventions Entry #1

B5a. Goal: The goal is to increase medication adherence, provide support in the achievement of health quality goals, and expand the proportion of the current clinical practice guidelines thereby slowing the progression of CAD, reducing the utilization of medical and surgical services, and/or preventing MI, stroke or heart failure.

B5b. Benchmark: The following year rate as the original benchmark being used: 112 months medical, surgical and pharmacy claims, and UM data per the 100 high risk members.

B5c. Goal Benchmark: Internal

B5d. Intervention: Along with the above described intensive disease management program and education we will provide the following: For the Member: Provider Education or Web Program - Mailings to the members, RN CM will educate on use and compliance

B5e. Rationale for Intervention: The CAD intervention was selected because when conducting the root-cause analysis of the issue it was discovered that our members were not taking their medications at appropriate intervals and/or their pharmacotherapy regimen was not according to the most current clinical practice guidelines. The related to goal for this education program will provide members with the needed follow up and knowledge to understand the rationale behind medication compliance.

B5f. Measurement Methodology: Medical, surgical and pharmacy claims and UM data reports will be collected and analyzed quarterly.

B5g. Timeline: 09-01-10 through 08-31-11

B6. Communications Sources including the Interdisciplinary Care Team and Patients

B6a. Sources: Electronic Communications (Webinars, portals, email, etc.)
 Surveys (Satisfaction Surveys, Comment Cards, Candidate Tracking, etc.)
 Telecommunications (Phone calls, phone text messages, public media, etc.)
 Face-to-Face Patient Education
 Written Materials (Brochures, provider newsletters, member newsletters, flyers, etc.)

B6b. Target Audience: Providers
 Case Manager
 Care Team
 Family Members

C. Plan Section Approval:

(Medical Director)

Name of Individual: John Test
Title: DR.
E-mail address: john.test@test.com
Phone: 201-223-7923 - 123
Date of Approval: 09/15/2010

Please review your responses for accuracy. To save the current information, please select the "Save" button.

Table II-12

HPMS

Home

CY 2011 CCIP - Submission

PLAN Section Confirmation

Your data has been saved.

OK

Go To: [CCIP Start Page](#)

CMS REGIONAL OFFICE APPROVAL

Once the user has completed the **PLAN Section**, the user's CMS Regional Office Account Manager (AM) will review the submission and determine whether it is approved or not. Each user will be notified of its approval status by the AM.

If an AM notifies the user of non-approval, the AM will provide the user with guidance and assistance on how to improve its submission. Once the user has worked with the AM to improve its submission, the user must re-submit the **PLAN section**. The user must re-enter information in sections where the information has changed when resubmitting specific sections of the *CCIP*.

Once the **PLAN section** is approved by the Regional Office AM, the user can begin to implement the *CCIP*.

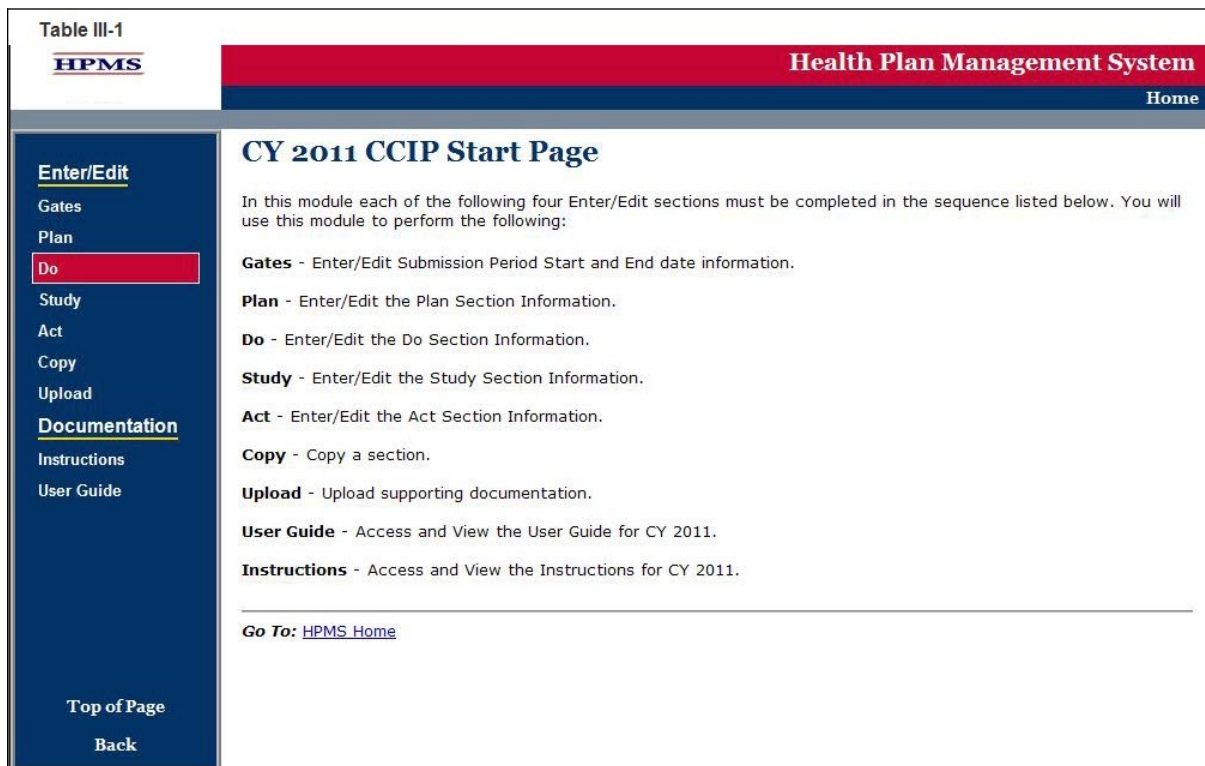
III. Do

The **DO** functionality allows users to describe the steps the MAO will take to conduct the *CCIP*.

The **DO Section** describes the actual education that the MAO has provided to the patient and/or provider. It also describes the *intervention(s)* that the MAO has implemented in order to achieve the program goal. This section describes the initial results or findings, *barriers* encountered (if applicable), *risk mitigation* plan for the identified *barriers*, and the anticipated impact on the goal and/or *benchmark* for any changes made due to the identified *barriers* and activation of the mitigation plan.

STEP 1

As shown in Table III-1, on the **CCIP Start Page** click on the **Do** link on the Left Navigation Bar to get to the **Contract/Plan/Topic Selection** screen. (See Chapter I: Getting Started for help getting to the *CCIP Start Page*.)



The screenshot shows the HPMS (Health Plan Management System) interface. The top navigation bar includes the HPMS logo and the text 'Health Plan Management System' with a 'Home' link. The main content area is titled 'CY 2011 CCIP Start Page'. A left-hand navigation menu lists various options: Enter/Edit, Gates, Plan, Do (highlighted in red), Study, Act, Copy, Upload, Documentation, Instructions, and User Guide. The main content area contains the following text: 'In this module each of the following four Enter/Edit sections must be completed in the sequence listed below. You will use this module to perform the following:'. Below this, a list of actions is provided: **Gates** - Enter/Edit Submission Period Start and End date information. **Plan** - Enter/Edit the Plan Section Information. **Do** - Enter/Edit the Do Section Information. **Study** - Enter/Edit the Study Section Information. **Act** - Enter/Edit the Act Section Information. **Copy** - Copy a section. **Upload** - Upload supporting documentation. **User Guide** - Access and View the User Guide for CY 2011. **Instructions** - Access and View the Instructions for CY 2011. At the bottom of the main content area, there is a 'Go To: [HPMS Home](#)' link. The left navigation menu also includes 'Top of Page' and 'Back' links at the bottom.

STEP 2

On the **Contract/Plan/Topic Selection** screen (Table III-2) first select a contract. Once the contract is selected, the screen will automatically refresh to show available plans. Users must create a unique QIP for each of the *SNPs* offered under a contract based on the *SNP's target population*. The *SNPs* are identified by their plan number. However, users may create the same

QIP for all of the non-SNP coordinated care plans offered under a contract. The non-SNP coordinated care plans under each contract are identified as ‘Non-SNP.’

Once a plan is selected, the screen will again automatically refresh to show the CCIP topics. Select an existing topic and then click **Next** to get to the **DO Section (E1)** screen.

Table III-2

HPMS Home

CY 2011 CCIP - Submission

DO Section – Contract/Plan/Topic Selection

NOTE: You will be unable to select a CCIP topic if you have not completed your "Plan Section."

Select a Contract:

- Z0001
- Z0002
- Z0003
- Z0004
- Z0005
- Z0006
- Z0007
- Z0008
- Z0009
- Z0010
- Z0011
- Z0012
- Z0013
- Z0014
- Z0015

Select a Plan:

- 006
- 007
- 009
- Non-SNP

Select a program:

- Coronary Artery Disease (CAD)

Next

Go To: [CCIP Start Page](#)

STEP 3

On the **DO Section (E1)** screen (Table III-3) select the type of education. The screen will then refresh to allow the user to enter information based on the type of education selected. Use the form displayed on the screen to describe detailed information about the method and topics used for education.

Cycle Period (auto-populates from section **A. MAO Information**)

E1. Education

The educational component may be focused on the patients, the providers, or both. Indicate if the education is patient focused, provider focused or a combination of both by selecting the appropriate option. The applicable tables will then be available for completion.

“E1a. Patient Self Management” and “E1b. Provider Education” are the actual educational topics and methods that were utilized during implementation of the *CCIP*. “B4a. Patient Self Management” and “B4b. Provider Education” from the Plan Section document the planned educational topics and methods. This section will not auto-populate because the Plan Section and the Do Section may not contain the same information.

E1a. Patient Self-Management

(Character Limit: 4,000)

For “E1a. Patient Self-Management,” if applicable, provide a detailed and in depth description of the actual methods of education and the educational topics that were used for training, support, monitoring, and follow-up of the members as applicable. The description must include: 1) methods that are varied and take into consideration the different demographics, socioeconomic status, and cultural backgrounds of the members; 2) educational topics that support improvement in health outcomes and are designed for various severity of disease levels, demographics, socioeconomic status, and cultural backgrounds of the members; and 3) training, support, monitoring, and follow-up.

E1a-1. Patient Self-Management–Other Comorbid Conditions

(Character Limit: 4,000)

For “E1a-1. Patient Self-Management–Other *Comorbid Conditions*” education, if applicable, provide a detailed and in depth description of the actual methods of education and the educational topics that the MAO used for training, support, monitoring, and follow-up of the members as applicable. The description must include: 1) methods that are varied and take into consideration the different demographics, socioeconomic status, and cultural backgrounds of the members; 2) educational topics that support improvement in health outcomes and are designed for different severity of disease levels, demographics, socioeconomic status, and cultural backgrounds of the members; and 3) training, support, monitoring, and follow-up.

E1b. Provider Education

(Character Limit: 4,000)

In “E1b. Provider Education,” a text box appears above the table to indicate the type of provider on which the education will focus.

For “E1b. Provider Education,” if applicable, provide a detailed and in depth description of the actual methods and educational topics that were used for provider training, support, monitoring, and follow-up. The description must include: 1) provider training on the applicable evidence-based guidelines and practice patterns for the identified disease state or condition; 2) methods for providing appropriate support for the members in managing their disease state or condition and monitoring of the member; and 3) methods and frequency for follow-up of the members.

Note:

- The *CCIP* module defaults to one *intervention* in this section. If necessary, the user can add more *interventions* by clicking **Add** near the bottom of the screen. Also, if additional *interventions* already exist for the *CCIP*, the user can delete an *intervention* by clicking **Delete**.
- If the *CCIP* already includes more than one *intervention*, then upon clicking **Next** the user will go to the **Plan Section (E1)** screen for the second *intervention*. Continue entering all information and clicking **Next** as appropriate until information has been entered for all *interventions*. After entering all information, the user will proceed to the **PLAN Section (E2)** screen.

After entering all information for all *interventions*, click **Next** to get to the **PLAN Section (E2)** screen.

CY 2011 CCIP - Submission

Enter/Edit - DO Section (E1)

MAO Name: EXAMPLE CONTRACT 1
Contract Number: Z0001
Identification Number: 009
Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)
Baseline Cycle Period: N/A

E. Program Implementation, Review and Revision

Education: Patient Self Management
 Provider Education
 Both

E1b. Provider Education: (Entry #1)	
Provider Education: Not Identified	
Method	Topics Covered
Training: Mail	Training: Current clinical practice guidelines
Support: Adherence to clinical practice guidelines	Support: Clinical pharmacists will provide monthly DUR and MTM reports to ensure adherence to the clinical practice guidelines.
Monitoring: Plan RN Case Manager phone calls	Monitoring: The RN case manager will do follow up phone calls with the member's PCPs following their appointment to identify any adjustments that were made to their medication regimen and/or if their health status changed.
Follow-up: Achievement of health quality goals	Follow-up: RN CM will provide documentation of the progress on the achievement of health quality goals for each member on a monthly basis.
Other: Survey	Other: A survey to evaluate the satisfaction with the program will be sent to each provider on a quarterly basis.

To enter additional Education, please select the "Add" button.

Add

Previous Next

STEP 4

On the **DO Section (E2)** screen (Table III-4) use the form displayed on the screen to describe program implementation.

E2. Intervention (auto-populates from section “B5d. *Intervention*”)

All of the *interventions* completed in the “B5. Outcome Measures and *Intervention*” table will auto-populate for up to three applicable *interventions*.

E3. Results or Findings

(Character Limit: 4,000)

For “E3. Results or Findings,” identified during implementation of the *CCIP* is an *analysis* of the results indicating achievement of the goal utilizing the *benchmark*, and anticipated outcomes which must include: 1) the date and cycle from which the data was collected; 2) the documentation of quantitative improvement; 3) how the *intervention* relates to the improvement; 4) the significance of the results; and 5) an explanation of factors influencing comparability and validity of the data.

E4. Barriers Encountered

(Character Limit: 4,000)

For “E4. *Barriers Encountered*,” provide a detailed and in depth description that includes: 1) the *barriers* that were encountered during implementation; 2) a *root cause analysis* of why the *barriers* occurred; and, 3) the magnitude of the impact the *barriers* had in preventing the goal from being attained.

If no *barriers* were encountered, please state “No *Barriers Encountered*” in the text field provided and enter “Not-Applicable” in fields E5 and E6.

E5. Mitigation Plan for Risk Assessment

(Character Limit: 4,000)

This element addresses the actual *barriers* encountered during implementation of the *CCIP* and needs to be completed if a *barrier* is identified in “E4. *Barriers Encountered*.” A mitigation plan is an action to correct significant problems that could prevent the stated goal from being reached in a *CCIP*.

For “E5. Mitigation Plan for Risk Assessment,” provides a detailed and in depth description that includes: 1) the changes that were made to overcome the *barriers* identified in “E4. *Barriers Encountered*;” 2) the factors considered to ensure that the changes were appropriate; and 3) the relationship between the changes implemented and how they are expected to reduce the impact of the *barrier*.

E6. Anticipated Impact on the Goal and/or Benchmark

(Character Limit: 4,000)

This element is completed only if a *barrier* was identified in “E4 *Barriers Encountered*”. The anticipated impact on the goal and/or *benchmark* is the outcome expected from any changes that

were made to mitigate *barriers* identified in “E4. *Barriers Encountered*” that might prevent the goal from being reached.

For “E6. Anticipated Impact on the Goal and/or *Benchmark*,” provide a detailed and in depth description that includes: 1) how the *risk mitigation* identified in “E5. Mitigation Plan for Risk Assessment,” will impact the goal and/or *benchmark*; 2) why the impact is expected; and 3) reliable source(s).

After entering all information, the user will proceed to the **Verification** screen. Click **Next** to get to the **Verification** screen.

CY 2011 CCIP - Submission

Enter/Edit - DO Section (E2)

MAO Name: EXAMPLE CONTRACT 1
Contract Number: Z0001
Identification Number: 009
Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)
Baseline Cycle Period: N/A

E. Program Implementation, Review and Revision

(Entry #1)

E2.

Intervention: Describe the actions taken or intervention implemented to achieve the goal. Along with the above described intensive disease management program and education we will provide the following: For the Member: Prefilled Medisets or Pill Organizers - Mailed out to the members. RN CM will educate on use and compliance.

E3. Results or Findings: Provide an analysis of the initial results or findings.

After four months of implementing the interventions, pharmacy claims were reviewed. For the members who were on automatic prescription refills, it seemed to be helping to keep them on track with taking their medications as prescribed, without any gaps between refills.

E4. Barriers Encountered: Describe the barriers encountered. (e.g., modification to intervention, strata targeted, measurement method, clinical, financial, resources utilized)

We encountered an obstacle with some of our members who get refills at local pharmacies. One of our interventions is to have monthly refill reminder calls. 10% of our members had the wrong telephone number listed in their demographics when this was implemented. It took extra time to contact the member with a wrong number on file, which resulted in some of our members having a gap in their prescription refills when they did not remember to get the refill without the reminder call.

E5. Mitigation Plan for Risk Assessment: Describe the actions taken to mitigate the barrier(s).

After the problem was discovered with some member phone numbers being incorrect, it was decided that every three months, demographics would be reviewed during one of the normal RN case manager phone calls with members.

E6. Anticipated Impact on the Goal and/or Benchmark: Describe the impact you expect the risk mitigation to have on the goal and/or benchmark.

Having the appropriate member demographics is important for many reasons, but it is essential with at least one of our interventions, which is a monthly refill reminder call for members five days before the prescription is due for a refill. Performing a three month demographic update will help ensure the plan has correct member information at all times, since members often forget to update their information if a phone number changes or if they move.

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Go To: [CCIP Start Page](#)

STEP 5

On the **Verification** screen (Table III-5) review all information for accuracy. Then click **Save** to ensure all information entered by the user is saved before the user proceeds on to the next section of the *CCIP*.

After clicking Save the user will be taken to the **DO Section Submission Confirmation screen** (Table III-6). Click **OK** to return to the *CCIP Start Page*.

CY 2011 CCIP - Submission

DO Section Verification

MAO Name: EXAMPLE CONTRACT 1
Contract Number: Z0001
Identification Number: 009
Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)
Baseline Cycle Period: N/A

Your data has not yet been saved.

Note: Once you select the "Save" button below, you may not update the PLAN section.

E. Program Implementation, Review and Revision	
Type of Education:	Provider Education
Provider Education:	Not Identified
E1b. Provider Education	
Provider Education Entry #1	
Method Training:	Mail
Method Support:	Adherence to clinical practice guidelines
Method Monitoring:	Plan RN Case Manager phone calls
Method Follow-up:	Achievement of health quality goals
Method Other:	Survey
Topic Covered Training:	Current clinical practice guidelines
Topic Covered Support:	Clinical pharmacists will provide monthly DUR and MTM reports to ensure adherence to the clinical practice guidelines.
Topic Covered Monitoring:	The RN case manager will do follow up phone calls with the member's PCPs following their appointment to identify any adjustments that were made to their medication regimen and/or if their health status changed.
Topic Covered Follow-up:	RN CM will provide documentation of the progress on the achievement of health quality goals for each member on a monthly basis.
Topic Covered Other:	A survey to evaluate the satisfaction with the program will be sent to each provider on a quarterly basis.
Program Implementation, Review and Revision #1	
E2. Intervention:	Along with the above described intensive disease management program and education we will provide the following: For the Member: Prefilled Medisets or Pill Organizers - Mailed out to the members. RN CM will educate on use and compliance.
E3. Results or Findings:	After four months of implementing the interventions, pharmacy claims were reviewed. For the members who were on automatic prescription refills, it seemed to be helping to keep them on track with taking their medications as prescribed, without any gaps between refills.
E4. Barriers Encountered:	We encountered an obstacle with some of our members who get refills at local pharmacies. One of our interventions is to have monthly refill reminder calls. 10% of our members had the wrong telephone number listed in their demographics when this was implemented. It took extra time to contact the member with a wrong number on file, which resulted in some of our members having a gap in their prescription refills when they did not remember to get the refill without the reminder call.
E5. Mitigation Plan for Risk Assessment:	After the problem was discovered with some member phone numbers being incorrect, it was decided that every three months, demographics would be reviewed during one of the normal RN case manager phone calls with members.
E6. Anticipated Impact on the Goal and/or Benchmark:	Having the appropriate member demographics is important for many reasons, but it is essential with at least one of our interventions, which is a monthly refill reminder call for members five days before the prescription is due for a refill. Performing a three month demographic update will help ensure the plan has correct member information at all times, since members often forget to update their information if a phone number changes or if they move.

Please review your responses for accuracy.

To save the current information, please select the "Save" button.

Previous

Save

CY 2011 CCIP - Submission

DO Section Confirmation

Your data has been saved.

OK


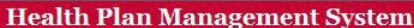


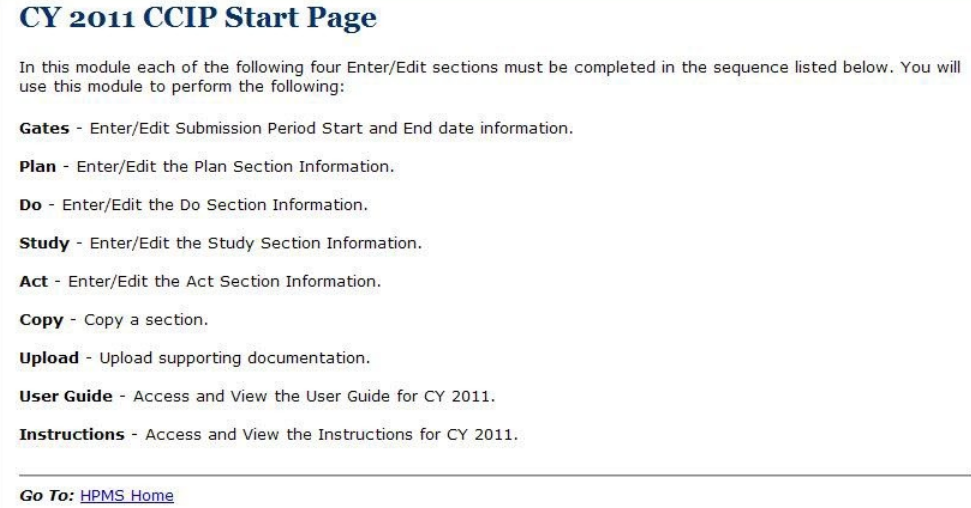
Go To: [CCIP Start Page](#)

IV. STUDY

The **STUDY** functionality allows users to describe the *CCIP* topic and report the results of the *CCIP*, as well as provide numerical data where applicable.

STEP 1

As shown in Table IV-1, on the **CCIP Start Page** click on the **Study** link on the Left Navigation Bar to get to the **Contract/Plan/Topic Selection** screen. (See Chapter I: Getting Started for help getting to the **CCIP Start Page**.)

Table IV-1	
	
	
	

STEP 2

On the **Contract/Plan/Topic Selection** screen (Table IV-2) first select a contract. Once the contract is selected, the screen will automatically refresh to show available plans. As stated in Chapter I, users must create a unique *CCIP* for each *SNP* offered under a contract based on the *SNP's target population*. The *SNPs* are identified by their plan number. However, users may create the same *CCIP* for all of the non-*SNP* coordinated care plans offered under a contract. The non-*SNP* coordinated care plans under each contract are identified as 'Non-*SNP*'.

Once a plan is selected, the screen will again automatically refresh to show *CCIP* topics. Select an existing topic and then click **Next** to get to the **STUDY Section (F)** screen.

Table IV-2

HPMS Home

CY 2011 CCIP - Submission

STUDY Section – Contract/Plan/Topic Selection

NOTE: You will be unable to select a CCIP topic if you have not completed your "Plan Section" and "Do Section."

Select a Contract:	Select a Plan:	Select a program:
<ul style="list-style-type: none"> Z0001 Z0002 Z0003 Z0004 Z0005 Z0006 Z0007 Z0008 Z0009 Z0010 Z0011 Z0012 Z0013 Z0014 Z0015 	<ul style="list-style-type: none"> 006 007 <li style="background-color: #e0e0e0;">009 Non-SNP 	<ul style="list-style-type: none"> <li style="background-color: #e0e0e0;">Coronary Artery Disease (CAD)

[Go To: CCIP Start Page](#)

STEP 3

On the **STUDY Section (F)** screen (Table IV-3) use the form displayed on the screen to describe the *CCIP* results for each *intervention*.

F. RESULTS

The goal, *benchmark*, and timeline will auto populate from the information provided in the PLAN Section. The dates of implementation, *sample size* or percent of total population, total percent or results, other data or results, and *analysis* of results or findings must be completed. The numerator and denominator should be completed if applicable. A separate results table will auto populate for each *intervention* identified in “B5d. *Intervention*.” Results must be reported for each *intervention*.

F1. Goal (auto-populates from section “B5a. Goal”)

F2. Benchmark (auto-populates from section “B5b. *Benchmark*”)

F3. Timeline

For “F3,” insert the dates for the “initial period” (i.e., the base year) that the *CCIP* has been implemented. If the *CCIP* is in its base year, the user will not report a “re-measurement period”. For multi-year programs, the MAO should report re-measurement period dates that align with their current program cycle year.

F4. Dates of Implementation

(Character Limit: 100)

For “F4. Dates of Implementation,” provide the exact beginning and ending dates of the program.

F5. Sample Size or Percent of Total Population

(Character Limit: 10)

For “F5. *Sample Size* or Percent of Total Population,” provide the *sample size* or percent of total population. The *sample size* should be reflective of the plan population. The data must be reported in this field as a whole number or percentage.

F6. Numerator

(Character Limit: 10)

For “F6. Numerator,” provide the number of plan members and/or data that met the *inclusion criteria*. Please note that this field may not be applicable if a numerator is not applicable. The data must be reported in this field as a whole number or percentage.

F7. Denominator

(Character Limit: 10)

For “F7. Denominator,” provide the number of plan members and/or data that were eligible to participate in the program. Please note that this field may not be applicable if a numerator is not available because a re-measurement period was not available. The data must be reported in this field as a whole number or percentage.

F8. Total Percent or Results

(Character Limit: 50)

For “F8. Total Percent or Results,” provide the total percentage or results of the study. The data must be reported in this field as a whole number or percentage.

F9. Other Data or Results

(Character Limit: 50)

For “F9. Other Data or Results,” provide additional data or results pertinent to the *CCIP*. Please note that this field allows for text and can capture results that are not numerical.

F10. Analysis of Results or Findings

(Character Limit: 50)

For “F10. *Analysis* of Results or Findings,” provides a description of the *analysis* of the results indicating achievement of the goal utilizing the *benchmark* and anticipated outcomes. The description must include: 1) the documentation of quantitative change or improvement; 2) how the *intervention* relates to the improvement; 3) the significance of the results; and 4) an explanation of factors influencing comparability and validity of the data.

Note:

- The *CCIP* module defaults to one *intervention* in this section. If necessary, the user can add more *interventions* by clicking **Add** near the bottom of the screen. Also, if additional *interventions* already exist for the *CCIP*, the user can delete a *intervention* by clicking **Delete**.
- If the *CCIP* already includes more than one *intervention*, then upon clicking **Next** the user will go to the **STUDY Section (F)** screen for the second *intervention*. Continue entering all information and clicking **Next** as appropriate until information has been

entered for all *interventions*. After entering all information, the user will proceed to the **Verification** screen.

After entering all information for all *interventions*, click **Next** to get to the **Verification** screen.

CY 2011 CCIP - Submission

Enter/Edit - STUDY Section (F)

MAO Name: EXAMPLE CONTRACT 1
Contract Number: Z0001
Identification Number: 009
Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)

F.Results

Intervention 1

Initial:
 (F1 - F10 in this section is required)

F1. Goal: The goal is to increase medication adherence, provide support in the achievement of health quality goals, and expand the application of the current clinical practice guidelines thereby delaying the progression of CAD, reducing the utilization of medical and surgical services, and/or preventing MI, stroke or heart failure.

F2. Benchmark: The following plan data is the internal benchmark being used: (12 months medical, surgical and pharmacy claims, and UM data per the 100 high risk members).

F3. Timeline:

F4. Dates of Implementation:

F5. Sample Size of Total Population: (Number)

F6. Numerator: (Skip if not applicable)

F7. Denominator: (Skip if not applicable)

F8. Total Percent or Result:

F9. Other Data or Results:

F10. Analysis of Results or Findings:

To enter additional Intervention, please select the "Add" button.

Go To: [CCIP Start Page](#)

STEP 4

On the **Verification** screen (Table IV-4) review all information for accuracy. Then click **Save** to ensure all information entered by the user is saved before the user goes on to the next section of the *CCIP*.

After clicking **Save**, the user will be taken to the **STUDY Section Submission Confirmation** screen (Table IV-5). Click **OK** to return to the *CCIP* Start Page.

Table IV-4

HPMS Home

CY 2011 CCIP - Submission

STUDY Section Verification

Your data has not yet been saved.

F. Results	
Intervention 1	
Initial Period: Not Identified.	
F1. Goal:	The goal is to increase medication adherence, provide support in the achievement of health quality goals, and expand the application of the current clinical practice guidelines thereby delaying the progression of CAD, reducing the utilization of medical and surgical services, and/or preventing MI, stroke or heart failure.
F2. Benchmark:	The following plan data is the internal benchmark being used: (12 months medical, surgical and pharmacy claims, and UM data per the 100 high risk members).
F3. Timeline:	Not Identified.
F4. Dates of Implementation:	09.01.10 through 08.31.11
F5. Sample Size of Total Population:	100
F6. Numerator:	
F7. Denominator:	
F8. Total Percentage or Result:	Data Not Available
F9. Other Data or Results:	Data Not Available
F10. Analysis of Results or Findings:	Data Not Available

Please review your responses for accuracy.
To save the current information, please select the "Save" button.

Go To: [CCIP Start Page](#)

CY 2011 CCIP - Submission

STUDY Section Confirmation

Your data has been saved.

OK


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V. ACT

The **ACT** functionality allows users to describe the *action plan* based on *CCIP* findings and captures the action taken after evaluating the results of the program or identifying achievement of the goal. The next steps for the *CCIP* must be identified in this section based on the results for this *program cycle year*.

STEP 1

As shown in Table V-1, on the **CCIP Start Page** click on the **Act** link on the Left Navigation Bar to get to the **Contract/Plan/Topic Selection** screen. (See Chapter I: Getting Started for help getting to the **CCIP Start Page**.)

Table V-1	
	Health Plan Management System
	Home
Enter/Edit	CY 2011 CCIP Start Page
Gates	In this module each of the following four Enter/Edit sections must be completed in the sequence listed below. You will use this module to perform the following:
Plan	Gates - Enter/Edit Submission Period Start and End date information.
Do	Plan - Enter/Edit the Plan Section Information.
Study	Do - Enter/Edit the Do Section Information.
Act	Study - Enter/Edit the Study Section Information.
Copy	Act - Enter/Edit the Act Section Information.
Upload	Copy - Copy a section.
Documentation	Upload - Upload supporting documentation.
Instructions	User Guide - Access and View the User Guide for CY 2011.
User Guide	Instructions - Access and View the Instructions for CY 2011.
	<hr/>
	Go To: HPMS Home
Top of Page	
Back	

STEP 2

On the **Contract/Plan/Topic Selection** screen (Table V-2) first select a contract. Once the contract is selected, the screen will automatically refresh to show available plans. As stated in Chapter I, users must create a unique *CCIP* for each *SNP* offered under a contract based on the *SNP's target population*. The *SNPs* are identified by their plan number. However, users may create the same *CCIP* for all of the non-*SNP* coordinated care plans offered under a contract. The non-*SNP* coordinated care plans under each contract are identified as 'Non-*SNP*'.

Once a plan is selected, the screen will again automatically refresh to show *CCIP* topics. Select an existing topic and then click **Next** to get to the **ACT Section (G1)** screen.

Table V-2

HPMS

Home

CY 2011 CCIP - Submission

ACT Section – Contract/Plan/Topic Selection

NOTE: You will be unable to select a CCIP topic if you have not completed your "Plan Section," "Do Section," and "Study Section."

Select a Contract:

Z0001
Z0002
Z0003
Z0004
Z0005
Z0006
Z0007
Z0008
Z0009
Z0010
Z0011
Z0012
Z0013
Z0014
Z0015

Select a Plan:

006
007
009
Non-SNP

Select a program:

Coronary Artery Disease (CAD)

Go To: [CCIP Start Page](#)

STEP 3

On the **ACT Section (G1)** screen (Table V-3) use the form displayed on the screen to summarize describe Next Steps for the study.

The Act Section captures the action taken after evaluating the results of the *CCIP* or identifying achievement of the goal. The next steps for the *CCIP* must be identified in this section based on the results for this *program cycle year*.

G. NEXT STEPS

Identify the next steps, based on the evaluation of the *CCIP* for this *program cycle year*, and whether the goals were met, or not met.

G1. Action Plan

“Program is complete” is selected only if the *CCIP* achieved the desired results and no additional steps are needed. If selecting this step, the reporting for the *CCIP program cycle year* is complete and may be submitted since no further information is required.

“Continue the program with no change(s)” is selected only if no changes are made to the *CCIP*. If selecting this step, reporting for the *CCIP program cycle year* is complete and may be submitted since no further information is required.

“Continue the program with change(s)” is selected only if changes are made to the *CCIP*. If selecting this step, complete each section of G3 through G9 as applicable.

G2. Planned Changes

(Character Limit: 4,000)

For “G2. Planned Changes,” provide a detailed and in depth description that includes: 1) the change(s) that will be implemented; 2) the rationale for the change(s); and 3) the factors considered that support that the stated change(s) is necessary and will benefit the program and the members.

G3. Develop a Quality Improvement Project (QIP) to study one or more aspects of the program

(Character Limit: 4,000)

For “G3. Develop a *Quality Improvement Project (QIP)* to study one or more aspects of the program,” provide a detailed and in depth description that includes: 1) the problem or opportunity for improvement; 2) the clinical significance or administrative/non-clinical significance; and 3) how the members will be positively impacted by the *QIP*.

G4. Discontinue the program

(Character Limit: 4,000)

For “G4. Discontinue the program,” provide a detailed and in depth description that includes: 1) the specific reasons why the *CCIP* will be discontinued; 2) the impact that discontinuing this program will have on plan members; and 3) how the members enrolled in the *CCIP* will be notified of the discontinuation.

G5. Re-evaluate and change the goal or benchmark selected (Character Limit: 4,000)

For “G5. Re-evaluate and change the goal or *benchmark* selected,” provide a detailed and in depth description that includes: 1) the change to the goal or *benchmark*; 2) the rationale for the change; and 3) the factors considered that show the stated change will improve health outcomes and benefit the program.

G6. Expand the program

(Character Limit: 4,000)

For “G6. Expand the program,” provide a detailed and in depth description that is consistent with the goal of the program and includes: 1) the expansion plans; 2) the expected impact that expanding the program will have on health outcomes; and 3) the proposed timeline.

Then click **Next** to go to the **ACT Section (G7)** screen.

CY 2011 CCIP - Submission

Enter/Edit - ACT Section (G1)

MAO Name: EXAMPLE CONTRACT 1

Contract Number: Z0001

Identification Number: 009

Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)

G. Next Steps

(Identify the next steps based on the evaluation of the CCIP for this cycle, whether the goals were met or not met.)

G1. Action Plan:

G2. Planned Changes

Patient Self Management has been discontinued.

G3. Develop a Quality Improvement Program (QIP) to study one or more aspects of the program

G4. Discontinue the program

G5. Re-evaluate and change the goal or benchmark selected:
New Goal or Benchmark

G6. Expand the program:

Expansion plans:

Due to the initial success of the program for the members with a high acuity it was decided to expand enrollment in the program to all members within our population who have CAD regardless of their acuity level.

Expected Outcomes:

It is expected that with extending the program to all members with CAD that disease progression will be decreased or remain stable thus improving health outcomes for all CAD members.

Proposed Timeline:

The expansion will start immediately. Members with CAD will be enrolled based on an opt-out method.

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STEP 4

On the **ACT Section (G7)** screen (Table V-4) use the form displayed on the screen to provide information about additional *interventions*.

G7. Identify additional *interventions*

(Character Limit: 4,000)

For “G7. Identify additional *intervention(s)*,” provide a detailed and in depth description that is consistent with the goal of the *CCIP* and includes: 1) the new *intervention* which includes a description of the factors considered that show that adding new *interventions* is appropriate; 2) the expected impact the new *intervention* will have on health outcomes; and 3) the proposed timeline.

Note:

- The *CCIP* module defaults to one *intervention* in this section. If necessary, the user can add more *interventions* by clicking **Add** near the bottom of the screen. Also, if additional *interventions* already exist for the *CCIP*, the user can delete an *intervention* by clicking **Delete**.
- If the *CCIP* already includes more than one *intervention*, then upon clicking **Next** the user will go to the **STUDY Section G7** screen for the second *intervention*. Continue entering all information and clicking **Next** as appropriate until information has been entered for all *interventions*. After entering all information, the user will proceed to the **Verification** screen.

After entering all information for all *interventions*, click **Next** to get to the **ACT Section (G8)** screen.

STEP 5

On the **ACT Section (G8)** screen (Table V-5) use the form displayed on the screen to provide any information about changes to data and criteria.

G8. Re-evaluate data and criteria

(Character Limit: 4,000)




For “G8. Re-evaluate data and criteria,” provide a detailed and in depth description that is consistent with the goal of the *CCIP* and include: 1) the rationale for re-evaluation of the data and criteria; 2) the changes that are anticipated to be made to the data and criteria; and 3) how the changes will benefit the program and health outcomes.

G9. Other

(Character Limit: 4,000)

For “G9. Other,” provide a detailed and in depth description of information that are not addressed in G3 through G8. The description must be consistent with the goal of the *CCIP* and include: 1) the MA plan’s next steps for the program; 2) how the next steps will affect the members and health outcomes; and 3) the factors considered that support the reason for the next steps.

Then click **Next** to get to the **Verification** screen.

Table V-5		
		
	Home	
CY 2011 CCIP - Submission		
Enter/Edit - ACT Section (G8)		
MAO Name: EXAMPLE CONTRACT 1		
Contract Number: Z0001		
Identification Number: 009		
Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)		
<input type="checkbox"/> G8. Re-evaluate data and criteria: Describe changes to data and criteria	<input type="text"/>	
<input type="checkbox"/> G9. Other	<input type="text"/>	
<input type="button" value="Previous"/>	<input type="button" value="Next"/>	
Go To: CCIP Start Page		

STEP 6

On the **Verification** screen (Table V-6) review all information for accuracy. Then click **Save** to go to the **ACT Section Confirmation** screen.

CY 2011 CCIP - Submission

ACT Section Verification

MAO Name: EXAMPLE CONTRACT 1

Contract Number: Z0001

Identification Number: 009

Chronic Care Improvement Program (CCIP) Topic: Coronary Artery Disease (CAD)

Your data has not yet been saved.

G. Next Steps	
G1. Action Plan:	Continue the program with change(s)
G2. Planned Changes:	Patient Self Management has been discontinued.
G3. Develop a Quality Improvement Program (QIP) to study one or more aspects of the program:	
G4. Discontinue the program:	
G5. Re-evaluated and change the goal or benchmark selected:	
G6. Expand the program	
Expansion plans:	Due to the initial success of the program for the members with a high acuity it was decided to expand enrollment in the program to all members within our population who have CAD regardless of their acuity level.
Expected Outcomes:	It is expected that with extending the program to all members with CAD that disease progression will be decreased or remain stable thus improving health outcomes for all CAD members.
Proposed timeline:	The expansion will start immediately. Members with CAD will be enrolled based on an opt-out method.
G7. Identify additional interventions	
(Intervention #1)	
New Interventions:	
Expected Outcomes:	
Proposed timeline:	
G8. Re-evaluate data and criteria	
G9. Other	

Please review your responses for accuracy.
To save the current information, please select the "Save" button.

Go To: [CCIP Start Page](#)

STEP 7

On the **ACT Section Confirmation** screen (Table V-7), click **Submit** to get to the **Submission Confirmation** screen (Table V-8).

Note: Please ensure your *CCIP* information is final prior to submission. Your *CCIP* information cannot be edited once the final *CCIP* is submitted.

Table V-7

HPMS Home

CY 2011 CCIP - Submission

ACT Section Confirmation

Your data has been saved.

Please ensure your CCIP Information is final. Your CCIP Information cannot be edited once the final CCIP is submitted.

To Submit the final CIP Information, please select the "Submit" button.

To go back to the selection criteria page, please select the "OK" button.

Go To: [CCIP Start Page](#)

Table V-8

HPMS Home

CY 2011 CCIP - Submission

CCIP Information Submission Confirmation

Your data has been submitted.

Contracts included with Submission		
Contract Number	Plan Number	Contract Name
Z0001	009	EXAMPLE CONTRACT 1

Individuals that will be Notified of Submission			
Contract Number	Role	Name	Email
Z0001	Medicare Compliance Officer	John Test	test@test.com
Z0001	Quality Contact	John Test	test@test.com
Z0001		John Test	test@test.com

Thank you for submitting your CCIP Information. An email will be sent to confirm your submission.

Go To: [CCIP Start Page](#)

VI. COPY

The **Copy** functionality allows users to Copy *CCIP* sections from one plan to another, as long as certain conditions exist. In particular:

- The PLAN section from one *CCIP* may be copied to a second *CCIP* if the second *CCIP* has no PLAN section or only has a PLAN section and no other sections.
- A section may be copied, if and only if, the auto-populated sections for both the source and target *CCIPs* are an exact match.
- When copying a section, the source and target sections cannot be for the same plan.

STEP 1

As shown in Table VI-1, on the **CCIP Start Page** click on the **Copy** link on the Left Navigation Bar to get to the **Criteria Selection** screen. (See Chapter I: Getting Started for help getting to the **CCIP Start Page**.)

Table VI-1	
HPMS	
Health Plan Management System	
Home	
Enter/Edit	CY 2011 CCIP Start Page
Gates	In this module each of the following four Enter/Edit sections must be completed in the sequence listed below. You will use this module to perform the following:
Plan	Enter/Edit -
Do	Gates - Enter/Edit Submission Period Start and End date information.
Study	Plan - Enter/Edit the Plan Section Information.
Act	Do - Enter/Edit the Do Section Information.
Copy	Study - Enter/Edit the Study Section Information.
Upload	Act - Enter/Edit the Act Section Information.
Documentation	Copy - Copy a section.
Instructions	Upload - Upload supporting documentation.
User Guide	Documentation -
	User Guide - Access and View the User Guide for CY 2011.
	Instructions - Access and View the Instructions for CY 2011.
	<hr/>
	Go To: HPMS Home
Top of Page	
Back	

STEP 2

On the **Criteria Selection** screen (Table VI-2) first select a section to copy.

Once the appropriate section is selected, the screen will automatically refresh to show available SOURCE contracts.

- Select the SOURCE contract and the screen will again automatically refresh to show available plans.
- Select the SOURCE plan and available CCIP topics will appear.
- Select the SOURCE CCIP topic to copy.

After selecting all sources, follow the same procedures to select the TARGET criteria. After selecting all TARGET criteria, click **Next** to get to the **Copy Verification** screen.

Table VI-2

HPMS Home

CY 2011 CCIP - Copy

Criteria Selection

1. Select a Section
 Section:

2. Select SOURCE Contract Criteria

Select a Contract:	Select a Plan:	Select a CCIP Topic:
<input type="text" value="Z0001"/> <input type="text" value="Z0002"/>	<input type="text" value="006"/> <input type="text" value="009"/>	<input type="text" value="Coronary Artery Disease (CAD)"/>

3. Select TARGET Contract Criteria

Select a Contract:	Select a Plan:	Select a CCIP Topic:
<input type="text" value="Z0003"/> <input type="text" value="Z0004"/>	<input type="text" value="Non-SNP"/>	<input type="text" value="Create a New Topic"/>

Go To: [CCIP Start Page](#)

STEP 3

On the **Copy Verification** screen (Table VI-3) review all information for accuracy, and then click **Copy** to get to the **Copy Confirmation** screen.

The **Copy Confirmation** screen included the following notes:

- Please remember to review the SOURCE data for accuracy before you copy the information.
- The PLAN section is the only section that you can create a new topic for the TARGET data.
- The TARGET information can still be edited for the Enter/Edit sections.

On the **Copy Confirmation** screen (Table VI-4) click **OK** to return to the **CCIP Start Page**.

Table VI-3

HPMS Home

CY 2011 CCIP - Copy

Copy Verification

NOTE:

- Please remember to review the SOURCE data for accuracy before you copy the information.
- The PLAN section is the only section that you can create a new topic for the TARGET data.
- The TARGET information can still be edited from the Enter/Edit sections.

1. Selected SOURCE Contract Criteria
Section:Plan
Contract:Z0001
Plan:009
Topic:Coronary Artery Disease (CAD)

2. Selected TARGET Contract Criteria
Contract:Z0003
Plan:Non-SNP
Topic:Copy of Coronary Artery Disease (CAD)

Go To: [CCIP Start Page](#)

Table VI-4

HPMS Home

CY 2011 CCIP - Copy

Copy Confirmation

The information is successfully duplicated and saved.

Go To: [CCIP Start Page](#)

VII. UPLOAD

Take the following steps to upload supporting documentation for the *CCIP*. All files must be uploaded in .zip format that is NOT password protected.

STEP 1

As shown in Table VII-1, on the **CCIP Start Page** click on the **Upload** link on the Left Navigation Bar to get to the **Criteria Selection** screen. (See Chapter I: Getting Started for help getting to the **CCIP Start Page**.)

Table VII-1	
HPMS	Health Plan Management System
	Home
Enter/Edit Gates Plan Do Study Act Copy Upload Documentation Instructions User Guide Top of Page Back	<h3>CY 2011 CCIP Start Page</h3> <p>In this module each of the following four Enter/Edit sections must be completed in the sequence listed below. You will use this module to perform the following:</p> <p>Enter/Edit -</p> <p>Gates - Enter/Edit Submission Period Start and End date information.</p> <p>Plan - Enter/Edit the Plan Section Information.</p> <p>Do - Enter/Edit the Do Section Information.</p> <p>Study - Enter/Edit the Study Section Information.</p> <p>Act - Enter/Edit the Act Section Information.</p> <p>Copy - Copy a section.</p> <p>Upload - Upload supporting documentation.</p> <p>Documentation -</p> <p>User Guide - Access and View the User Guide for CY 2011.</p> <p>Instructions - Access and View the Instructions for CY 2011.</p> <hr/> <p>Go To: HPMS Home</p>

STEP 2

On the **Contract/Plan/Topic Selection** screen (Table VII-2) first select a contract. Once the contract is selected, the screen will automatically refresh to show available plans. Then select a plan and the screen will again automatically refresh to show *CCIP* topics. Select an existing topic.

After selecting the contract, plan and topic, select **Browse** to locate the .zip file being uploaded. Then click **Next** to get to the **Upload Confirmation** screen (Table VII-3).

CY 2011 CCIP - Upload

Once a Contract/Plan/CCIP Topic is selected, please upload supporting documentation in a zipped file format. The zipped file must NOT be password protected.

Criteria Selection

Select a Contract:

Z0001
Z0002

Select a Plan:

006
007
009
Non-SNP

Select a CCIP Topic:

Coronary Artery Disease (CAD)

Select file for upload: C:\Documents and Settings Browse...

Next

Go To: [CCIP Start Page](#)

CY 2011 CCIP - Upload

Once a Contract/Plan/CCIP Topic is selected, please upload supporting documentation in a zipped file format. The zipped file must NOT be password protected.

Upload Confirmation

The file is successfully uploaded and saved.

OK

Go To: [CCIP Start Page](#)

APPENDIX I: CONTACT INFORMATION

Subject Matter	Name	Phone	Email Address / Web Address
<ul style="list-style-type: none">HPMS Technical Help	HPMS Help Desk	800-220-2028	HPMS@cms.hhs.gov
<ul style="list-style-type: none">Password Reset Requests	CMS Action Desk	410-786-2580	N/A

APPENDIX II: GLOSSARY OF TERMS

Action Plan	A defined or organized process or steps taken to achieve a particular goal or to reduce the risk of future events.
Analysis	A systematic evaluation of the data and/or results of the project/program.
Barrier	An obstruction or something that impedes; anything that prevents progress or makes it difficult to achieve the desired goal or expected outcome.
Baseline Data	Baseline data is basic information gathered from the plan population before a program or project begins. It is used later to provide a comparison for assessing the impact of the project or program after it has been implemented.
Baseline Year	The year the program/project is first implemented.
Benchmark	<p>A point of reference by which something can be measured, compared, or judged. It can be an industry standard or internal baseline against which a program indicator is monitored and found to be above, below or comparable to the benchmark.</p> <ul style="list-style-type: none">• Baseline Benchmark – Data obtained at the end of the current reporting cycle as the standard of comparison for subsequent reporting cycles. The first measure used as a point of reference in which a project or program can be measured, compared, or judged.• External benchmark – 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 internal results against to determine the level of success or failure of the program/project.• Internal benchmark - Data used from the plan’s own data sources (e.g., administrative data or claims data) for comparison.
Chronic Care Improvement Program (CCIP)	A set of interventions designed to improve the health of individuals who live with multiple or sufficiently severe chronic conditions, and includes patient identification and monitoring. Other programmatic elements may include the use of evidence-based practice guidelines, collaborative practice models involving physicians as well as support-service providers, and patient self-management techniques. (Publication 100-16 Medicare Managed Care Manual, Chapter 5)

Comorbid Conditions	A disease, disorder, or condition that occurs simultaneously with another disease, disorder, or condition.
Evidence-based Medicine	The practice of making clinical decisions using the best available research evidence, clinical expertise, and patient values.
Intervention	The Agency for Healthcare Research and Quality (AHRQ) defines intervention as “A change in process to a health care system, service, or supplier, for the purpose of increasing the likelihood of optimal clinical quality of care measured by positive health outcomes for individuals.”
Methodology	The means, technique, procedure, or method used to collect data or measure the effectiveness of a program/project or intervention.
Plan, Do, Study, Act (PDSA)	A quality improvement model that is cyclical in nature and includes planning, implementing, studying a change, and acting on the results of that change.
Program/Project Cycle Year	Cycle year refers to a logical sequence of activities to accomplish the program or project’s goals or objectives. The CCIP program cycle year and the QIP project cycle year each begin on an established date. Together, each cycle of PDSA is a full cycle year. Subsequent cycle years begin on the anniversary of the beginning of the first program or project year. The cycle year may be independent of the CMS review cycle.
Quality Improvement Project (QIP)	An organization’s initiative that focuses on specified clinical and non-clinical areas to improve enrollee satisfaction and health outcomes. (Publication 100-16 Medicare Managed Care Manual, Chapter 5)
Sample Size	The selection of a representative subgroup of plan members or units from the whole plan population. Sample size is expressed numerically and must be large enough to provide a valid representation of the entire population.
Special Needs Plan (SNP)	An MA coordinated care plan that limits enrollment to special needs individuals who are 1) institutionalized, 2) dually eligible for Medicare and Medicaid, or 3) diagnosed with a severe or disabling chronic condition. (Publication 100-16 Medicare Managed Care Manual, Chapter 16b)
Target Population/Audience	A selected group of MA plan members that meet eligibility criteria for participation in a CCIP or QIP.