Medicare-Medicaid Plan (MMP) - Care Coordination & Quality Improvement Program Effectiveness (CCQIPE) Program Area
AUDIT PROCESS AND DATA REQUEST

Comments in Worksheet format – Sent to: MMCOCapsModel@cms.hhs.gov

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Protocol & Page Number	Description of Issue or Question	Suggested Revision/Comment
CC-QIPE, page 5, 6, 7, 9, 12	***Issue: Universe Requests and background documentation– data burden***	There is a fairly large amount of new information requested, such as cumulative claims by subgroup, new elements in documentation for cases—and a very short timeframe in which to query multiple data sources/systems and organize the information. More detail is provided in subsequent comments. This represents additional burden on plans.
CC-QIPE , page 15, 16, 17 – Columns U, V, W, X, Y, Z, AA, AB, AC, AD, AE, AF	***Issue: With the stratification and cumulative claims requested, there is a lot more programming that will need to be done to accommodate these new data requests by group***	Cumulative claims data, and data by stratified subgroup, have not previously been requested. We are unclear about the intended purpose for these elements. How will these be reviewed, interpreted, used—and linked back to the standards for CC & QIPE? If plans are expected to produce cumulative claims data as requested, they will need a phase-in and process-building time period to be able to comply. There will need to be more data analytics programming done in order to retrieve,

		organize, and report on these data elements. For example, both the care management and claims data systems need to be linked to find the right information for cases. Reports may not exist on these elements in these stratified groups. In addition, some data elements pertain to services for the member where claims are not run through the health plan. Health plans operating in different states may be especially challenged to create one set of programs for these data requests by universe/cases—as the states differ in benefit and eligibility design. We note that LTSS may be especially challenging. Finally, the cumulative claims data will likely not be inclusive of all services provided—as there are typically lag times between provision and claims submission—at times these are more than 90 days.
CC-QIPE, page 7	Sample Case Documentation – "completed HRAs and member's ICP" ***Q: What does "completed" mean and in what formats should the HRA or ICP be?*** *Recognizing some ICPs are maintained at various provider settings, (e.g., those working with the member on psychosocial, LTSS, medical, and behavioral health issues) which are not accessible to the health plan electronically.*	Please define "completed" and exceptions to these completions for cases of member refusals to the HRA or member refusals to participate in the ICP development. Please define allowable formats for HRA and ICP documentation, recognizing these may be maintained in other settings/other electronic systems that are not accessible to the plan—e.g., require manual retrieval by a provider or service. Please give plans ample time to request records from providers where needed—given the number of service provider types, including behavioral health where there are restrictions on data sharing, this is likely take more than 30 days.
CC-QIPE, HRA - pages 7 & 8	HRA Compliance Standard 3.1.1. Did the MMP conduct the initial HRA? ***Q: If member refusals are documented***	Would want to confirm the following would "count" toward meeting this standard: *Member refusals based on multiple contact attempts (e.g., 3 attempts within the year) and documented are to be considered, so that the plan is excused for this case if such*

	with multiple attempts to complete HRA, does this provide for exclusion for that case under audit?	*documentation is present.*
CC-QIPE, page 7	Compliance Standard on HRAs: 3.1.2 (HRA timeframe) ***Q: What are allowable exceptions to the timeframe?"***	Please confirm that there are allowable exceptions to this timeframe, such as: the member was hospitalized, out of town, or unable to be reached based on multiple document contact attempts.
CC-QIPE, page 7	Compliance Standard on HRAs: 3.1.4 (HRA domains) ***Q: What does "completed" mean?***	Please confirm that Member refusals (on answering questions from one or more specific domains on the HRA)—refusals that are documented --would be considered as a "completed HRA."
CC-QIPE, page 8	Compliance Standard on HRAs: 3.1.6 (personnel) ***Q: Plans with delegate agencies conducting HRAs – confirm professional credentials as specified in those contracts are sufficient.***	Would want to confirm the following: MMP contracts may allow delegate agencies—the professional credentials would therefore be specified in that subcontract and this would meet the standard.
CC-QIPE, page 8	Compliance Standard on HRAs: 3.1.7 (Setting) ***Q: "Appropriate setting" may differ by member and does need to take into account member's preferences. Can this be clarified in the standard, case review and audit template?***	This (setting/location) item has not been asked previously, and could vary widely (therefore not easily categorized) and is not a data field that has been required or even set up for data collection – therefore plans will need to have some time to begin collecting these data and determine where/how to collect with appropriate specifications. This cannot be put into place immediately. Also, we would want to confirm the following: CMS standard allows for member preferences and circumstances for location of HRA, e.g., homeless person in shelter, individual who does not want a home visit but would meet in public location, etc. This happens more frequently in working with low-income and diverse populations. To increase HRA completion, plans

		accommodate member preferences as much as they can. As noted, however, the location/setting has not been a required data point for HRA documentation.
CC-QIPE, page 12 – Column ID J, K	**Issue:** ***Need to modify template/column and response options to accommodate exclusions and exceptions to HRA as noted above***	Need "NA" or "EX" as an approved response option as described/noted above. "Not applicable" or "Excluded" for the field character responses allowed
CC-QIPE, page 12 – Column O	**Issue:** ***Setting for HRA – new documentation would need to be put in place.***	Location/setting - This has not been asked previously. The place could vary widely (therefore not easily categorized) and this is not a data field that has been required or even set up for data collection – therefore plans will need to have some time to begin collecting these data and determine where/how to collect with appropriate specifications. This cannot be put into place immediately. Please provide time for implementation. The HRA tool itself may need to be modified.
CC-QIPE, page 8	Compliance standard on ICPs 3.2.2 (specific interventions) ***Q: If there is no HRA, but there are other assessments done (e.g., medical/behavioral health) and an ICP developed – how is this handled?*** ***Q: Interventions that are preferred may not be available—how to address this.***	Need to recognize that other assessments, beyond the HRA may be used to generate a care plan that is interdisciplinary and that includes member goals and preferences. The audit on specific interventions desired should take into account following: interventions and services must be available in the area and fall under allowable services as defined by contract – state and CMS rules.
CC-QIPE, page 8	Compliance Standard on ICPs 3.2.4 (ICP review) ***Q: Standard for "appropriate frequency"?***	We understand that it is difficult to gauge a clear/specific standard for "appropriate frequency." We would like that the Audit protocol provide guidance to reviewers/auditors to note that a spectrum of member conditions may indicate different timeframes for frequency in terms of checking the plan—and may be done by different providers (e.g.,
CC-QIPE, page 8	Compliance Standard on ICPs 3.2.6 (member/caregiver participation) ***Issue: Member refusal/ member***	We agree this is important. Note, however, that the member may not wish to involve a family member /caregiver at times and may himself/herself refuse

	preferences.	involvement. The "facilitation" efforts should be documented in these case so that this standard element can be considered met.
CC-QIPE, page 8	Compliance Standard on ICPs 3.2.7 (coordination of communication of the ICP) ***Issue: Communication authorities, pathways, systems – across spectrum.***	Note that communication channels among the various providers may come from wide variety of behavioral health, medical, social services, as well as informal service providers, caregiver(s) and the member himself/herself. Capacity for receiving /providing information about the ICP may vary widely in terms of how, when, and in what form they can receive or provide information. The MMP can demonstrate commitment to this communication coordination and sharing but will need to respect the parameters of the providers and other agencies/people involve—and in all cases conform to State and federal privacy guidelines that pertain.
CC-QIPE, page 8	Compliance Standard on ICTs 3.3.1 (composition) ***Q: Standard for ICT disciplines***	We note that the members' needs drive the desired composition of the team—in some cases the member's behavioral health needs are primary and a behavioral health counselor, psychiatrist, pharmacist, and social worker would be the most critical members of the ICT for that member. For others, with moderate state dementia, the key team members may be the neurologist, nurse practitioner, and caregiver, as well as a social worker or community caregiver consultant. The composition of the team will also be influenced by member/caregiver preferences. We request that if there are specific universal standards across states and for every member that the auditors are looking for, it would be helpful to specify those required disciplines. Otherwise, both the state contract, and provider/service networks and standards of care for that member's needs—will drive the ICT composition.

CC-QIPE, page 9	QIPE Review Documentation ***Issue: There are new documentation requirements that will be added burden on plans.***	We note that the request for performance monitoring reports is new. Health plans may need additional time to organize this information.
Overall	***Coordination issue on quality audits***	We note that these audits represent a significant amount of information gathering and are an intense process -- beginning and lasting up to one month or more, when considering special data programming, case-specific information, and universe as defined and scope. Therefore, we request that CMS consider timing of these MMP audits in order NOT to overlap with other audits/reviews, e.g., MA-PD—by several months
Overall	***Reporting findings***	We request that findings provided by auditors will be specific to the state in which the member was served—as plans with multiple contracts/plans across states need this specificity in order to better pinpoint issues that may be affected by particular state contract parameters, plan or provider actions/processes, or other state-specific differences.

Medicaid Medicare Plan (MMP) Service Authorization Requests, Appeals and Grievances (SARAG) Program Area
AUDIT PROCESS AND DATA REQUEST
SNP Alliance Comments 3-16-2017

Comments in Worksheet format –Sent to: MMCOCapsModel@cms.hhs.gov

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Protocol & Page Number	Description of Issue or Question	Suggested Revision/Comment
SARAG, Page 3, Item 2.	**Review Period Timing:** Timing of issuance of protocol is too close to audit periods to collect additional data needed.	We are concerned about the timing of issuance of this protocol, since it is being released only days prior to the start of its potential scheduled utilization for actual audits. Where there are changes, additions and other differences between this protocol and previously applied audit protocols, MMPs have not had a chance to prepare for collection of additional data. It may require considerable manual work to collect additional data in a short period of time. Manual processes are not as consistent as automated processes, disadvantaging plans and making them vulnerable to errors. Further, while CMS has requested comment on this protocol, the sample timeline noted in this section would not appear to allow much time to consider comments and make applicable revisions. CMS should wait

		six months after final publication to implement this protocol in order to allow time for plans to develop data collection methods.
SARAG, Page 3, Item 2.	**Review Period Length.** The Review Period and thus data collection period is too close to audit period and may not allow for collection of some data.	CMS should be aware that for some items requested, such as claims, data may not be available for all Universe cases due to provider billing practices. Providers are generally allowed to submit claims outside this three month look back period. While CMS has exempted provider claims from the timeliness tests in the protocol and allows an NA for claims not available on Table 3, it is not clear what this means for the overall audit results. Recognizing that such instances may be rare in cases related to appeals, CMS should clarify how such instances will be handled, and assure that claims that have not yet been submitted by providers will not impact audit results.
SARAG, Page 3, Item 4, Item 9	**Calculation of Score:** Instructions are not clear that results of MMP audits will not impact Star Ratings or other MA product audit results.	It is our understanding that CMS does not intend for MMP results to impact other MA product lines. If this is correct, the instructions are confusing. CMS should clarify that results of these scores do not impact Star Ratings or other MA product audit results or scores. There has been confusion among some plans with multiple products on this point due especially to statements that these results will be included in Part C and D audit results.
SARAG, Page 4, Item 10	**Informing MMP of Results:** Need clarification that MMP audits are reported separately from Part C and D program audit reports. Results should be	The reference to inclusion of MMP product results in Part C and D program audit reports is confusing. CMS should clarify that MMP audits will apply only to MMP products, and will be reported separately from other products and enrollments. In addition, CMS should clarify that audit

	reported in a state specific approach.	results should be state specific since MMP designs and contracts are state specific. Thus state specific results should be shared with each corresponding state accordingly with the exception of best practice results which should be shared across states. Finally, as noted above, MMP results should not impact Star Ratings or performance results of other MA products.
SARAG, Page 5, Item 1.	**Responding to Universe Request:** Short timelines for programming impede consistent collection of new data elements and education of providers.	CMS should note that some of the data requested from providers, especially physician offices, call logs and notes from delegates, may be difficult to obtain within the short time frame allowed for response. Because this protocol is being issued so close to the audit review periods, there will not be time for plans to educate providers, change collection systems, or implement programming necessary to capture some of this information on an automated basis. Some plans may have to collect it manually, which will require additional time. CMS should take this into account upon first use of this protocol or should delay the use of the protocol for six months to allow time for plans to prepare and address these issues.
SARAG, Page 6, Item 3	**Submit Universes to CMS:** Data submitted is not specific to MMPs in different states, impeding state specific results.	CMS instructs plans not to submit data for state specific MMPs. This raises issues of how audits from one state may affect MMP performance results and thus contracts in another state. It could also reduce the usefulness and understanding of audit findings for individual states. Where states may have different procedures or contract requirements, results may not accurately reflect plan performance in a given state, further complicating sharing

		and utilization, value of results, as well as ability to follow up on results. CMS should not assume that plans operate similarly in every state. Individual states may have different political, economic, work force climates, and policy goals. CMS should clarify how state specific results can be achieved under this protocol.
SARAG, Page 8, Item 2.1	**Audit Elements.** SAR process does not seem to recognize role of MMP care coordinator.	Frequent references to CSR, physician and member submitting SARs ignores role of care coordinator in facilitating SARs especially for MLTSS services. In some plans Care Coordinators may have the ability to process and even directly approve SARs for MLTSS service on behalf of the members. Some of these audit procedures do not appear to reflect this practice.
SARAG, Page 9, Item 2.1	**Audit Elements.** Claims payment records may not be available during review period.	Providers typically have more than 3 months in which to submit bills.
SARAG, Page, 17, Item L. Comment also applies to Page 22 M, page 27 L, page 30 M, page 34 N, Page 38 H, page 47 K, page 49 L.	**Table 1. SAR Record Layout**. Categorizing services by type may require additional time and effort from plans.	Call log information may be difficult to collect as it may exist in many places. Call logs may not routinely capture descriptions of the call. Calls are often highly complex and lengthy covering multiple topics as plan representatives try to assist members with real life issues. Also the protocol focuses on information from customer services instead of MMP care coordinators where information may actually be more directly relevant.
Page 51, Table 12.	**Table 12, Call Logs.** Call log information expected is unwieldy, may not include information expected, will be difficult to	Call log information may be difficult to collect as it may exist in many places. Call logs may not routinely capture descriptions of the call. Calls are often highly complex and

	format and may not yield the most relevant information.	lengthy covering multiple topics as plan representatives try to assist members with real life issues. Also the protocol focuses on information from customer services instead of MMP care coordinators where information may actually be more directly relevant.