MMP-CCQIPE Audit Process and Data Request Protocol
Crosswalk of Significant Updates from 2018 to 2020
Updated language has been italicized in the 2020 Protocol Language column.

Update No.	Section in 2018 Protocol	2018 Protocol Language	Clarification or Change	2020 Protocol Language
1	Audit Purpose and General Guidelines: Review Period	NA	Added a note to explain that more than one version of a demonstration's 3-way contract might apply to the CCQIPE review if the audit review period spans the effective period of more than one of the demonstration's contract versions.	*The 13 month review period could span years that might be subject to different versions of the three-way contract executed between the Medicare-Medicaid Plan (MMP), State, and CMS depending on when the contract was last updated.*
2	Audit Purpose and General Guidelines: Calculation of Score	NA	Added language that explains how CCQIPE program area audit performance affects the overall sponsor/ MMP audit score. The language is standard across each program Audit Process and Data Request protocol.	*CMS will then add the score for that audit element to the scores for the remainder of the audit elements in a given protocol and then divide that number (i.e., total score), by the number of audit elements tested to determine the sponsor's overall MMP-CCQIPE audit score. Some elements and program areas may not apply to certain sponsors and therefore will not be considered when calculating program area and overall audit scores. Observations will be recorded in the draft and final reports, but will not be scored and therefore will not be included in the program area and audit scores.*

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3	Universe Preparation & Submission: Pull Universes and Submit Background Information	NA	Added language that gives sponsors with multiple MMPs the option to submit QIPE universes as one upload to CMS.	*MMPs may opt to submit one workbook with a separate tab for each MMP contract, or may submit multiple workbooks within a single zip file.*
4	Universe Preparation & Submission: Pull Universes and Submit Background Information	NA	Added a supplemental questionnaire to the list of background information MMPs are required to submit in advance of the CCQIPE review. The questionnaire will have an earlier due date than the other background documentation listed in this section, as questionnaire responses will be used by the CMS Audit Team to have preparatory conversations with the MMP that will ensure a more efficient audit process.	• *Responses to a supplemental questionnaire on care coordination policies and procedures related to HRAs, ICPs, and the ICT.* This documentation will have the same submission deadline as the universes, except for the supplemental questionnaire, *which will be due 5 business days after receipt of the audit engagement letter.*
5	Audit Elements: Care Coordination: Select Sample Cases	CMS will select a sample of 30 members from the MMPM universe submitted. The sample selection will be provided to the MMP by the close of business on the Wednesday before the week the MMP-CCQIPE audit begins.	CMS will provide sample selections to the MMP following the same timeframe as specified in the 2020 Special Needs Plan Model of Care (SNP MOC) Audit Process and Data Request sample selection, which aligns with the Thursday before the audit week.	CMS will select a sample of 30 members from the MMPM universe submitted. The sample selection will be provided to the MMP by the close of business on the *Thursday* before the week the MMP-CCQIPE audit begins.

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6	Audit Elements: Care Coordination: Apply Compliance Standard: HRAs	3.1.8. Does the MMP utilize a contracted vendor that administers the HRA? If so, has the vendor implemented policies and procedures that match and comply with the contract and CMS requirements?	Compliance standard 3.1.8. will no longer be assessed through the MMP-CCQIPE review and was removed from the protocol.	NA
7	Appendix: Table 1: Medicare-Medicaid Plan Members (MMPM) Record Layout: Column ID D Field Name and Description	Cardholder ID: Cardholder identifier used to identify the member. This is assigned by the plan.	As a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, starting January 1, 2020, all MMPs must use the Medicare Beneficiary Identifier (MBI). The MMPM Record Layout Column D now requires the Medicare Beneficiary Identifier (MBI) in lieu of the Cardholder ID.	Member ID: Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.