Commonwealth of Puerto Rico
Puerto Rico Health Insurance Administration

Annual External Quality Review Technical Report

Contract Years:
Medicaid 2016-2017
Medicare 2016-2017

FINAL REPORT

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Table of Contents

List of Tables

I. Overview

Purpose of Report

The Balanced Budget Act of 1997 established that state agencies contracting with Medicaid managed care organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the State agency and the MCO. Subpart E – External Quality Review of 42 Code of Federal Regulations (CFR) sets forth the requirements for annual external quality review (EQR) of contracted MCOs and prepaid inpatient health plans (PIHPs). CFR 438.350 requires states to contract with an External Quality Review Organization (EQRO) to perform an annual external quality review (EQR) for each contracted MCO or PIHP. The states must further ensure that the EQRO has sufficient information to carry out the EQR; that the information be obtained from EQR related activities; and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicaid and Medicare Services (CMS). Quality, as it pertains to EQR, is defined in 42 CFR 438.320 as "the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge."

These same federal regulations require that the annual EQR be summarized in a detailed technical report that aggregates, analyzes and evaluates information on the quality, timeliness and access to health care services that MCOs and PIHPs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the plans regarding health care quality, timeliness and access, and make recommendations for improvement. Finally, the report must assess the degree to which any previous recommendations were addressed by the MCOs and PIHPs.

To meet these federal requirements, the Puerto Rico Health Insurance Administration (PRHIA) (also known as Administracion de Seguros Salud de Puerto Rico [ASES]) has contracted with IPRO, an External Quality Review Organization, to conduct the annual EQR of Puerto Rico's Medicaid managed care (MMC) plans and the Medicare Advantage Organizations (MAOs) contracted under the Medicare program.

Scope of EQR Activities Conducted

This EQR technical report focuses on the three federally mandated EQR activities that were conducted. As set forth in 42 CFR 438.358, these activities were:

Compliance review: This review determines MCO/PIHP compliance with its contract and with State and federal regulations in accordance with the requirements of 42 CFR 438.204 (g) (Standards for Access, Structure and Operation, and Measurement and Improvement).

Validation of Performance Measures (PMs): IPRO conducted Healthcare Effectiveness Data and Information Set (HEDIS®) compliance audits of the MCO/PIHP processes for calculation and reporting of HEDIS performance measures for HEDIS 2016. For HEDIS 2017 IPRO was not the audit firm for HEDIS 2017 but has reviewed the HEDIS 2017 audit reports provided by each MCO audited by a certified HEDIS vendor.

Validation of Performance Improvement Projects (PIPs): PIPs for the subject time period were reviewed for each plan to ensure that the projects were designed, conducted and reported in a methodologically sound manner, allowing real improvements in care and services and giving confidence in the reported improvements.

The results of these three EQR activities performed by IPRO are detailed in sections III, IV, and V. A description of the strengths and weakness of each plan are found in section VI. Section VI also includes recommendations for each plan. Section VII includes each plan's response to recommendations identified in the prior EQR technical report.

Contract years 2016-2017 reviewed for performance measures and PIPs.

Contract years 2014-2015 are reported for compliance reviews.

II. Background

Puerto Rico Medicaid Managed Care Program

Puerto Rico's Medicaid Office, representing the Department of Health of Puerto Rico and the Puerto Rico Health Insurance Administration (PRHIA), contracted with IPRO to conduct the EQR of the health plans participating in the Medicaid Program for Policy Year 2016-2017 as set forth in 42 CFR §438.356(a)(1). After completing the EQR process, IPRO prepared this *2016-2017 External Quality Review Technical Report for Puerto Rico Medicaid Managed Care,* in accordance with 42 CFR §438.364, that describes the manner in which data from activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and how conclusions were drawn as to the *quality, timeliness*, and *access* to the care furnished to Puerto Rico's Medicaid recipients by their MCOs/PIHPs.

This report provides a description of the following EQR activities conducted:

- Monitoring of the compliance with standards
- Validation of performance measures
- Validation of PIPs

This report presents the findings for all the health plans participating in the Puerto Rico's Medicaid Managed Care Program during Policy Year 2016-2017. Medicaid recipients may also be eligible for Medicare coverage. These dual-eligible recipients are provided coverage through Medicare Advantage Organizations (MAOs). In Puerto Rico Medicare Advantage plans are called Platino plans. This report also presents the findings for Puerto Rico Platino plans.

Medicaid MCOs reviewed:

- First Medical Health Plan, Inc (First Medical)
- MMM Multi Health, LLC (MMM)
- Molina Healthcare of Puerto Rico (Molina)
- Triple-S Salud (Triple-S)

Medicare Advantage organizations (Platino) reviewed:

- Constellation Health, LLC (Constellation)
- Humana Health Plans of Puerto Rico, Inc (Humana)
- MCS Advantage, Inc (MCS)
- MMM Healthcare, LLC (MMM Platino)
    - PMC Medicare Choice (PMC)[1]
- Triple-S Advantage Inc (Triple-S Platino)

Since compliance has not been reviewed since contract years 2014-2015, the compliance findings for 2014-2015 are included in this report. The findings reported here first appeared in the prior EQR technical report.

Compliance was reviewed in 2014-2015 for the following MCOs.

Medicaid MCOs reviewed:

- APS Healthcare (Behavioral Health)
- First Medical
- MMM
- PMC

[1] PMC Medicare Choice is a MAO with MMM as the parent company. In data provided to IPRO sometimes PMC is reported separately from MMM at other times both MMM and PMC is reported together.

- Molina
- Triple-S

Medicare Advantage organizations (Platino) reviewed:

- Constellation
- Humana Health Plan
- Medical Card Systems
- MMM
- PMC
- Triple-S

Since April 1, 2015, the government health program embodied a new service model which transforms Puerto Rico's health system by integrating physical and behavioral health and improving access to quality primary and specialty care services. Under this new model, the government health program previously referred to as *Mi Salud* is transformed into the Government Health Plan (GHP).

Puerto Rico Health Insurance Administration Quality Goals and Objectives

The PRHIA presented the *Medicaid Quality Strategy for Puerto Rico* to CMS on March 1, 2007. An updated Quality Strategy was developed by Puerto Rico for 2015 and established the following goals and objectives for Puerto Rico's GHP and its contracted health plans:

1. Improve timely access to preventive care screening and visits for all GHP Medicaid, Commonwealth, CHIP and Platino dual eligible enrollees. The expected increment in preventive and screening services should be by at least 3% annually:

    a. Cancer screenings for breast and cervical
    b. Asthma management
    c. Cholesterol management for high risk populations
    d. Diabetes care management
    e. Antidepressant medication management
    f. Follow-up care for children with prescribed ADHD medication
    g. Follow-up after hospitalization for mental illness and engagement of alcohol and other drug dependence treatment
    h. Identification of alcohol and other drug treatment services
    i. Behavioral health utilization
    j. Annual preventive dental visits
    k. Preventive care visits
    l. Timeliness in prenatal care
    m. HIV testing in the first and third trimester of pregnancy

For Medicare Platino plans:

    a. Glaucoma screening for older adults
    b. Colorectal cancer screening

2. Improve quality of care and behavioral health screening provided to all GHP Medicaid, Commonwealth, CHIP and Platino dual eligible enrollees through an integrated model of service delivery. The expected increment in behavioral health screening services should be by at least 50%:

    a. Pregnant women registered by quarter for alcohol and tobacco use with 4P Plus screening tool
    b. Screening for postpartum women for depression using Edinburgh screening tool
    c. Screening of children using Ages and Stages Socio-emotional (ASQ-SE)

d. Screening of adult members registered in Special Coverage for depression using PHQ-9 screening tool

3. Improve member's satisfaction with provided services and primary care experience. Rates are expected to reach the average score established by the Agency for Healthcare Research and Quality (AHRQ) in the composite items:

Consumer Assessment of Healthcare Providers and Systems (CAHPS):

a. Rating of personal doctor
b. Rating of all health care
c. Rating of health plan

Experience of Care and Health Outcomes (ECHO) Survey:

a. Getting treatment quickly
b. How well clinicians communicate
c. Getting treatment and information from the plan
d. Perceived improvement
e. Information about treatment options
f. Overall rating of counseling and treatment

III. Compliance Review

CMS requires a review, within the previous three-year period, to determine a health plan's compliance with federal Medicaid managed care regulations, state regulations, and state contract requirements. ASES has requested IPRO include compliance reviews from contract years 2014-2015. The following "Review of Medicaid [Medicare] Managed Care Organization Compliance with Regulatory Requirements" sections are reproduced here unaltered from the previous Puerto Rico Annual External Quality Review Technical Report covering contract years 2014-2015.

Review of Medicaid Managed Care Organization Compliance with Regulatory Requirements

This section of the report presents the results of the reviews by IPRO of Puerto Rico MCO/PIHPs' compliance with regulatory standards and contract requirements for contract year 2014-2015. The information is derived from IPRO's conduct of the annual compliance reviews in October 2016.

A review, within the previous three (3) year period, to determine the MCO's compliance with federal Medicaid managed care regulations, State regulations, and State contract requirements is a mandatory EQR activity as established in the Federal regulations at 42 CFR §438.358(b)(3).

Requirements contained within CFR 42 Subparts C: Enrollee Rights, D: Quality Assessment and Performance Improvement, F: Grievance System and H: Program Integrity was reviewed. For reporting year 2016, First Medical, MMM, PMC and Molina received full reviews and APS (Behavioral Health) and Triple-S received partial reviews. **Table 1** displays the domains that were reviewed for each plan for the 2014–2015 review period.

Table 1: Annual Medicaid Compliance Reviews – Domains by Plan

Topic	APS (BH)	First Medical	MMM	PMC	Molina	Triple-S
Grievance System	X	X	X	X	X	X
Enrollee Rights	X	X	X	X	X	X
Program Integrity	X	X	X	X	X	X
QAPI: Access	X	X	X	X	X	
QAPI: Structure and Operations		X	X	X	X	
QAPI: Measurement and Improvement	X	X	X	X	X	X

Summary results of the 2016 Compliance Review findings are shown in **Table 2**. Overall results indicate 97% of all elements reviewed were scored full compliance or substantial compliance, while only 3 % of all elements received minimal or non-compliance findings and thus required corrective action.

Table 2: Summary Results of 2016 Medicaid Managed Care 2016 Compliance Review Findings

Summary of 2016 Medicaid Managed Care Compliance Review Findings[2] (Review Year 2015)					
	Total Number of Elements Scored (% of Total)				
Standard	Total	Full Compliance	Substantial Compliance	Minimal Compliance	Non-Compliance
APS Healthcare (Behavioral Health)	122	83(68%)	21(17%)	13(11%)	5(4%)
First Medical	122	258 (94%)	13 (4%)	1 (0.5%)	4 (1.5%)
MMM	279	268 (96%)	9 (3%)	2 (1%)	0 (0%)
PMC	289	278(96%)	9 (3%)	2 (1%)	0 (0%)
Molina	278	260(94%)	15 (5%)	3 (1%)	0 (0%)

[2] This table has been modified since the original publication in the 2014-2015 EQR report. Errors were identified in the PMC and MMM number of elements scored. This table has been corrected.

Summary of 2016 Medicaid Managed Care Compliance Review Findings[2] (Review Year 2015)					
	Total Number of Elements Scored (% of Total)				
Standard	Total	Full Compliance	Substantial Compliance	Minimal Compliance	Non-Compliance
Triple-S	115	104 (90%)	2 (2%)	3 (3%)	6 (5%)
Overall	**1,359**	**1,251 (92%)**	**69 (5%)**	**24 (2%)**	**15 (1%)**

A description of the content evaluated under each domain follows:

- Grievance System – The evaluation of the Grievance System included, but was not limited to, review of: policies and procedures for grievances and appeals, file review of member and provider grievances and appeals, MCO program reports on appeals and grievances, QI committee minutes, and staff interviews.

- Enrollee Rights and Protection – The evaluation in this area included, but was not limited to, review of: policies and procedures for member rights and responsibilities, PCP changes, documentation of advance medical directives and medical record keeping standards. Also reviewed were informational materials including the Member Handbook, processes for monitoring provider compliance with advance medical directives and medical record keeping standards; and evidence of monitoring, evaluation, analysis, and follow up regarding advance medical directives.

- Program Integrity *(new for 2015)* – The evaluation in this area included, but was not limited to, review of MCOs' policies and procedures, training programs, reporting and analysis; compliance with Annual Disclosure of Ownership (ADO) and financial interest provisions; and file review of program integrity cases.

- Quality Assessment and Performance Improvement (QAPI):Access – The evaluation of this area included, but was not limited to, review of: policies and procedures for direct access services; provider access requirements; program capacity reporting; case management and care coordination; utilization management; evidence of monitoring program capacity for primary care, specialists, hospital care, and ancillary services; as well as evidence of evaluation, analysis and follow up related to program capacity monitoring. Additionally, file review for case management and utilization management was conducted.

- Quality Assessment and Performance Improvement (QAPI):Measurement and Improvement – The evaluation in this area included, but was not limited to, review of: Quality Improvement (QI) Program Description, Annual QI Evaluation, QI Work Plan, QI Committee structure and function, including meeting minutes; Performance Improvement Projects (PIPs), HEDIS Final Audit Report, documentation related to performance measure calculation, reporting and follow up; and evidence of internal assessment of accuracy and completeness of encounter data.

- Quality Assessment and Performance Improvement (QAPI): Structure and Operations – The evaluation in this area included, but was not limited to, review of policies and procedures for excluded providers, credentialing and re-credentialing, enrollment and disenrollment, and tracking of disenrollment data. File review for credentialing and re-credentialing was conducted. Subcontractor contracts and oversight was also received.

File reviews were conducted for the following:

- Grievance File Review: Files were assessed for the following:
  - Completeness of documentation
  - Timeliness of resolution
  - Format and content of communications to the enrollee
  - Use of appropriately qualified clinical staff to conduct reviews

- Appeals File Review: Files were assessed for the following:

- Completeness of documentation
- Timeliness of resolution
- Providing the enrollee/representative the opportunity to present evidence
- Providing the enrollee/representative the opportunity to examine the case file
- Including required parties as party to the appeal
- Timeliness of resolution for both standard and expedited appeals
- Provision of notice of action to the enrollee – oral and/or written
- Format and content of written notices to the enrollee
- Use of appropriately qualified clinical staff to conduct reviews

- Utilization Management File Review: Files were assessed for the following:
  - Completeness of documentation
  - Format and content of written notices to the enrollee
  - Use of language to ensure ease of understanding for the enrollee
  - Clear statement of the MCO action to be taken
  - Clear statement of the reason for the MCO action
  - Inclusion of the enrollee/provider right to file an appeal with the MCO, the right to request a State Fair Hearing, and process for requests
  - Notice to the enrollee of circumstances for expedited resolution and how to request it
  - Notice the enrollee of the right to continue benefits pending resolution, and the possibility of financial responsibility
  - Timeliness of resolution
  - Use of appropriately qualified clinical staff to conduct reviews

- QAPI: Access – Care Management File Review: Files were assessed for the following:
  - Collaborative development of the case management plan
  - Assessment of member needs
  - Identification of goals and interventions
  - Monitoring of progress

The following section summarizes the 2016 Compliance Review findings for each Medicaid Managed Care plan and provides a description of each of the elements found to be minimally compliant or non-compliant.

APS Healthcare 2016 Medicaid Compliance Review Findings for Contract Year 2014–2015

A summary of the Medicaid compliance results for APS Healthcare is provided below. For each standard, the following is provided: current year overall category compliance designations; and a description of the current year findings for all standards/elements found minimally or non-compliant.

Table 3: APS – Summary of 2016 MMC Compliance Review Findings

APS Healthcare: Summary of 2016 Medicaid Managed Care Compliance Review Findings (Review Year 2014–2015)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	6	1	3	2	0
Enrollee Rights and Protections	1	0	1	0	0
Program Integrity	91	81	2	4	4
Quality Assessment and Performance Improvement (QAPI) – Access	1	0	1	0	0

APS Healthcare: Summary of 2016 Medicaid Managed Care Compliance Review Findings (Review Year 2014–2015)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations					
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	23	1	14	7	1
Total #/% of Total	**122**	**83(68%)**	**21(17%)**	**13(11%)**	**5(4%)**

Table 4: APS – 2016 MMC Compliance Review: Minimal and Non-Compliant Elements

APS Healthcare: 2016 Medicaid Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014–2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	• Acknowledge receipt of each grievance and appeal. **Minimal Compliance:** The plan should provide an acknowledgment of receipt especially in those instances where the appeal is not resolved within 10 working days of receipt. • Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process. **Minimal Compliance:** The member must be informed of the right to examine the case file with the initial denial, acknowledgement letter, and resolution notice.
Enrollee Rights and Protections	• All applicable requirements were Compliant.*
Program Integrity	• At a minimum, the Contractor shall include in each report, with respect to individual investigations of Fraud, Abuse, or Waste: d) Type of Provider; **Minimal Compliance:** The plan should add the type of provider to its files. f) All communication between the Contractor and the provider about the complaint; **Minimal Compliance**: The plan should add the requirement to a policy or procedure. h) Approximate dollars involved or amount paid to the provider during the past three years, whichever is greater; **Minimal Compliance:** As noted by the Plan that the report has a column titled "Approximate Dollars Involved". On the reports, the column was either blank or noted as "TBD". As per the requirement, the Plan should list the approximate or actual dollars involved for each complaint. • The Contractor shall report to ASES, within (1) one business day of obtaining knowledge with respect to the identity of any provider or other person who, in violation of 42 CFR 438.610 (a) and (b), is debarred, suspended, or otherwise prohibited from participating in procurement activities. **Non-Compliance:** Review of the Plan's credentialing and re-credentialing policies and procedures indicated that these documents did not contain any language that addresses the (1) one day reporting requirement.

APS Healthcare: 2016 Medicaid Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014–2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
	• Each Company has five (5) days to notify ASES about the referrals made to the US Attorney's Field Office and HHS-OIG. **Non-Compliance:** No documentation was submitted that addresses this requirement. • Each Company has five (5) days to notify ASES about any adverse or negative action that the MCO has taken on provider application (upon initial application or application renewal) or actions which limit the ability of providers to participate in the program. **Non-Compliance:** No documentation was submitted that addresses this requirement. • Each Company must comply with requirement in 42 CFR 455.20 and must document in a quarterly report compliance with regulation. **Non-Compliance:** The Plan did not submit documentation and/or any policies and procedures that meet the requirement. • The organization will select a sample to perform independent reviews to verify that recipient's services billed by providers (as well as encounters under capitated environment) were indeed rendered. This review will be performed through confirmations to beneficiaries. **Minimal Compliance:** The plan should develop a procedure that addresses the requirement.
Quality Assessment and Performance Improvement (QAPI) – Access	• All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	• MCOs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. **Minimal Compliance:** The Plan should ensure that QIPs are evaluated on an ongoing basis, with updated results presented in QI Work Plan and discussed in the QI Committee. Interventions should be modified as results indicate, and process measures should be reported so that the impact of interventions can be evaluated. The Plan should ensure that dated results and complete documentation of dated, well-defined measures are submitted for review for each QIP for compliance. • MCOs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following: **(i)** Measurement of performance using objective quality indicators. **Minimal Compliance:** The Plan should clearly define and present the QIP indicators, including measurement timeframes (baseline, and re-measurement periods), for all active QIPs. **(ii)** Implementation of system interventions to achieve improvement in quality. **Minimal Compliance:** The Plan should clearly define and present the QIP interventions (including implementation timeframes/dates), track and report process measures so that interventions can be evaluated, provide analyses of the impact of interventions, and revise interventions based on barrier analyses and performance outcomes for all active QIPs. The Annual QI Program Evaluation should report full analysis of all QIP results. **(iii)** Evaluation of the effectiveness of the interventions. **Minimal Compliance:** QIPs should be evaluated on an ongoing basis, updated in QI Work Plans, discussed in QI Committee meetings and interventions should be modified as results indicate. The Annual QI Program Evaluation should report full analysis of all QIP results. **(iv)** Planning and initiation of activities for increasing or sustaining improvement. **Minimal Compliance:** The Plan should ensure that barrier analyses are conducted for each QIP topic and that interventions are

APS Healthcare: 2016 Medicaid Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014–2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
	developed that address specific barriers. Process measures should be tracked and reported to facilitate evaluation of effectiveness of interventions, and interventions should be modified based on results of evaluation as needed. The QI Work Plan, QI Program Description and QI Program Evaluation should document these efforts. • Each MCO must report the status and results of each project to the State as requested, including those that incorporate the requirements of §438.240(a)(2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year. **Non-Compliance:** The Plan should include QIP results in the QI Evaluation, and complete QIP reports (including defined objectives, indicators, timeframe for measurement and results) should be submitted for compliance review. • The State must review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The review must include— **(ii)** The results of each MCO's performance improvement projects. **Minimal Compliance:** The Plan should include a complete discussion of QIP results, with analysis and proposed next steps in the QI Program Evaluation, as described in the Program Description. • Make all collected data available to the State and upon request to CMS, as required in this subpart. **Minimal Compliance:** The Plan should address encounter data processes in policy and procedure and monitor accuracy and completeness of data submitted to ASES. Evidence of submission of collected data to the State and CMS should be provided.

*Compliance is defined as having Full or Substantial Compliance.

First Medical Medicaid Compliance Review Findings for Contract Year 2014–2015

A summary of the Medicaid compliance results for First Medical is provided below. For each standard, the following is provided: current year overall category compliance designations; and a description of the current year findings for all standards/elements found minimally or non-compliant.

Table 5: First Medical – Summary of 2016 Medicaid Managed Care Compliance Review Findings

First Medical: Summary of 2016 Medicaid Managed Care Compliance Review Findings (Review Year 2014–2015)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	48	47	1	0	0
Enrollee Rights and Protections	49	47	2	0	0
Program Integrity	92	83	5	0	4
Quality Assessment and Performance Improvement (QAPI) – Access	43	43	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	20	15	4	1	0

Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	24	23	1	0	0
Total #/ (% of Total)	**276**	**258 (93%)**	**13 (5%)**	**1 (0.4%)**	**4 (1%)**

*Percentages may not equal 100% due to rounding

Table 6: First Medical – 2016 Medicaid Managed Care Compliance Review: Minimal and Non-Compliant Elements

First Medical: 2016 Medicaid Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014–2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	• All applicable requirements were Compliant.*
Enrollee Rights and Protections	• All applicable requirements were Compliant.*
Program Integrity	• Each Company has five (5) days to notify ASES about the referrals made to the US Attorney's Field Office and HHS-OIG. **Non-Compliance:** Not addressed in Policies and Procedures. • Each Company has five (5) days to notify ASES about any adverse or negative action that the MCO has taken on provider application (upon initial application or application renewal) or actions which limit the ability of providers to participate in the program. **Non-Compliance:** Documentation could not be found that reflects the requirement of notification to AES within 5 days. • The PIP must include the process to guarantee that a full investigation must continue until: a. appropriate legal action is initiated, b. the case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse, c. the matter is resolved between the organization and the provider or recipient. **Non-Compliance:** Unable to find evidence of documentation of the requirement in the Plan's Compliance Program document, Fraud, Waste and Abuse Policy nor any other documents submitted by the Plan. • The resolution may include but is not limited to: a. Sending a warning letter to the provider or recipient, giving notice that continuation of the activity in question will result in further action. **Non-Compliance:** Unable to find evidence of documentation of the requirement in the Plan's Compliance Program document, Fraud, Waste and Abuse Policy nor any other documents submitted by the Plan.
Quality Assessment and Performance Improvement (QAPI) – Access	• All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	• Credentialing and re-credentialing requirements. (1) Each State must establish a uniform credentialing and re-credentialing policy that each MCO must follow. (2) Each MCO must follow a documented process for credentialing and re-credentialing of providers who have signed contracts or participation agreements with the MCO. **Minimal Compliance:** Plan needs to revise Provider application to include the referenced information.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	• All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

MMM Medicaid Compliance Review Findings for Contract Year 2014–2015

A summary of the Medicaid compliance results for MMM is provided below. For each standard, the following is provided: current year overall category compliance designations; and a description of the current year findings for all standards/elements found minimally or non-compliant.

Table 7: MMM – Summary of 2016 Medicaid Managed Care Compliance Review Findings

MMM: Summary of 2016 Medicaid Managed Care Compliance Review Findings (Review Year 2014–2015)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	48	45	2	1	0
Enrollee Rights and Protections	49	46	3	0	0
Program Integrity	92	92	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	45	45	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	20	17	2	1	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	25	23	2	0	0
Total # (% of Total)	**279**	**268 (96%)**	**9 (3%)**	**2 (1%)**	**0**

Table 8: MMM – 2016 Medicaid Managed Care Compliance Review: Minimal and Non-Compliant Elements

MMM: 2016 Medicaid Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014–2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	• Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.) **Minimal Compliance:** The plan should update the "Standard Notification of Denial of Health Coverage" to provide for submitting the appeal in person.
Enrollee Rights and Protections	• All applicable requirements were Compliant.*
Program Integrity	• All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Access	• All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	• ***Disenrollment requested by the MCO*** **-** All MCO contracts must—**(2)** Provide that the MCO may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees); **Minimal Compliance:** MMM should ensure all contract language is addressed in the Provider Guidelines.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	• All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

PMC Medicaid Compliance Review Findings for Contract Year 2014–2015

A summary of the Medicaid compliance results for PMC is provided below. For each standard, the following is provided: current year overall category compliance designations; and a description of the current year findings for all standards/elements found minimally or non-compliant.

Table 9: PMC – Summary of 2016 Medicaid Managed Care Compliance Review Findings

PMC: Summary of 2016 Medicaid Managed Care Compliance Review Findings (Review Year 2014–2015)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	48	45	2	1	0
Enrollee Rights and Protections	49	46	3	0	0
Program Integrity	92	92	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	45	45	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	30	27	2	1	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	25	23	2	0	0
Total #/ (% of Total)	**289**	**278 (96%)**	**9 (3%)**	**2 (1%)**	**0 (0%)**

Table 10: PMC – 2016 Medicaid Managed Care Compliance Review: Minimal and Non-Compliant Elements

PMC: 2016 Medicaid Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014–2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	• ***Special requirements for appeals***. The process for appeals must: **(2)** Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.) **Minimal Compliance:** The plan should update the "Standard Notification of Denial of Health Coverage" to provide for submitting the appeal in person.
Enrollee Rights and Protections	• All applicable requirements were Compliant.*
Program Integrity	• All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Access	• All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	• ***(b) Disenrollment requested by the MCO;*** All MCO contracts must — **(2)** Provide that the MCO may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees); **Minimal Compliance:** PMC should assure that all contract language is included in the Provider Guidelines.

PMC: 2016 Medicaid Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014–2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	• All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

Molina Medicaid Compliance Review Findings for Contract Year 2014–2015

A summary of the Medicaid compliance results for Molina is provided below. For each standard, the following is provided: current year overall category compliance designations; and a description of the current year findings for all standards/elements found minimally or non-compliant.

Table 11: Molina – Summary of 2016 Medicaid Managed Care Compliance Review Findings

Molina: Summary of 2016 Medicaid Managed Care Compliance Review Findings (Review Year 2014–2015)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	48	35	10	3	0
Enrollee Rights and Protections	49	47	2	0	0
Program Integrity	92	92	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	44	43	1	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	20	18	2	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	25	25	0	0	0
Total #/ (% of Total)	**278**	**260 (94%)**	**15 (5%)**	**3 (1%)**	**0 (0%)**

Table 12: Molina – 2016 Medicaid Managed Care Compliance Review: Minimal and Non-Compliant Elements

Molina: 2016 Medicaid Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014–2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	• **(b) *Content of notice*.** The notice must explain the following: **(6)** The circumstances under which expedited resolution is available and how to request it. **Minimal Compliance:** The plan should ensure all member utilization requests have notices including circumstances under which expedited resolution is available and how to request it, whether or not sent directly by the plan, and whether it is a medical or pharmacy related notification. **(7)** The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services. **Minimal Compliance:** The plan should ensure all member utilization requests have notices including continuation of benefits pending resolution

Molina: 2016 Medicaid Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014–2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
	of appeal, whether or not sent directly by the plan, and whether it is a medical or pharmacy related notification. • **(d) *Format of notice.***(1) Grievances. The State must establish the method the MCOs and PIHPs will use to notify an enrollee of the disposition of a grievance. **Minimal Compliance:** The plan should ensure members are notified of the disposition.
Enrollee Rights and Protections	• All applicable requirements were Compliant.*
Program Integrity	• All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Access	• All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	• All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	• All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

Triple-S Medicaid Compliance Review Findings for Contract Year 2014–2015

A summary of the Medicaid compliance results for Triple-S is provided below. For each standard, the following is provided: current year overall category compliance designations; and a description of the current year findings for all standards/elements found minimally or non-compliant.

Table 13: Triple-S – Summary of 2016 Medicaid Managed Care Compliance Review Findings

Triple-S: Summary of 2016 Medicaid Managed Care Compliance Review Findings (Review Year 2014–2015)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	7	7	0	0	0
Enrollee Rights and Protections	1	0	0	1	0
Program Integrity	92	82	2	2	6
Quality Assessment and Performance Improvement (QAPI) – Access					
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations					
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	15	15	0	0	0
Total #/ (% of Total)	**115**	**104 (90%)**	**2 (2%)**	**3 (3%)**	**6 (5%)**

Table 14: Triple-S – 2016 Medicaid Managed Care Compliance Review: Minimal and Non-Compliant Elements

Triple-S: 2016 Medicaid Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014–2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	• All applicable requirements were Compliant.*
Enrollee Rights and Protections	• The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must provide the following information to all enrollees: **(ix)** The post-stabilization care service rules set forth at 422.113(c) of this chapter. **Minimal Compliance:** The member manual and Enrollee Rights policy do not sufficiently state the requirements listed. Please include all requirements listed in 422.113(c) in the Enrollee Rights Policy or create a separate internal policy on Post-stabilization services. This is strongly suggested so that internal staff and customer service can inform members on the health plan's financial responsibility for post-stabilization services.
Program Integrity	• The Contractor shall not knowingly have a relationship with the following: a. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under Executive Order No. 12549. **Minimal Compliance:** The Ongoing Monitoring of Providers policy describes the process by which the plan monitors its providers. Missing from the documentation is language that states the requirement. The Contractor shall not knowingly have a relationship with the following: b. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in (a) above. The relationship is defined as follows: (1) a director, officer, or partner of the Contractor; (2) a person with beneficial ownership of five percent of more of the Contractor's equity; or (3) a person with an employment, consulting or other arrangement with the Contractor for the provision of items or services that are significant and material the Contractor's obligations under this Contract. **Minimal Compliance:** Language that states this requirement is missing from the Ongoing Monitoring of Providers policy document. • The Contractor shall report to ASES, within (1) one business day of obtaining knowledge with respect to the identity of any provider or other person who, in violation of 42 CFR 438.610 (a) and (b), is debarred, suspended, or otherwise prohibited from participating in procurement activities. ASES shall promptly notify the Secretary of HHS of the noncompliance, as required by 42 CFR 438.610(c). **Non-Compliance:** This requirement is not found in a policy or procedure. • The Contractor and all subcontractors shall cooperate fully with federal and Puerto Rico agencies in Fraud and Abuse investigations and subsequent legal actions. Such cooperation shall include providing, upon request, information, access to records, and access to interview employees and consultants, including but not limited to those with expertise in the administration of the program and/or medical or pharmaceutical questions or in any matter related to an investigation. **Non-Compliance:** This requirement is missing form a policy or procedure. • Each Company has five (5) days to notify ASES about any adverse or negative action that the MCO has taken on provider application (upon initial application or application renewal) or actions which limit the ability of providers to participate in the program. **Non-Compliance:** This requirement is not found in a policy or procedure.

Triple-S: 2016 Medicaid Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014–2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
	• Each Company should develop and implement procedures to report to HHS-OIG and ASES within 20 working days any criminal conviction disclosures made during the MCO credentialing process. Copy of the policies should be submitted to ASES Compliance Office. **Non-Compliance:** This requirement is not found in a policy or procedure. • Each Company must submit to the Compliance Office a certification signed by the Compliance Director and the President or CEO stating compliance with 42 CFR 455.106. **Non-Compliance:** This requirement is not found in a policy or procedure. • The PIP must recommend that the organization have in the provider's contract a disclaimer that states as a contracted provider any data related to services or payments provided must be available for review of the integrity staff. **Non-Compliance:** This requirement is not addressed in the PIP or in the Provider Contract.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	• All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

Review of Medicare Organization Compliance with Regulatory Requirements

This section of the report presents the results of the 2016 reviews by IPRO of Puerto Rico Platino MCOs' compliance with regulatory standards and contract requirements for contract year 2015. The information is derived from IPRO's conduct of the annual compliance reviews in October 2016. Requirements contained within CFR 42 Subparts C: Enrollee Rights, D: Quality Assessment and Performance Improvement, F: Grievance System and H: Program Integrity were reviewed.

For reporting year 2016, all Platino plans received partial reviews as outlined in **Table 33**.

Table 15: Annual Medicare Compliance Reviews – Domains by Plan

Topic	Constellation Health	Humana	MCS	MMM	PMC	Triple-S
Grievance System	X		X		X	X
Enrollee Rights			X			X
Program Integrity	X	X	X	X	X	X
QAPI: Access	X	X				
QAPI: Structure and Operations	X		X			X
QAPI: Measurement and Improvement	X	X	X	X	X	X

Summary results of the 2016 Compliance Review findings are shown in **Table 34**. Overall results indicate 92% of all elements reviewed were scored full compliance or substantial compliance, while 8% of all elements received minimal or non-compliance findings and thus required corrective action.

Table 16: Summary Results of 2016 Medicare Managed Care Compliance Review Findings

Summary of 2016 Medicare Managed Care Compliance Review Findings (Review Year 2015)					
	Total Number of Elements Scored (% of Total)				
Standard	Total	Full Compliance	Substantial Compliance	Minimal Compliance	Non-Compliance
Constellation Health	152	123 (81%)	5 (3%)	13 (9%)	11 (7%)
Humana	113	79 (70%)	16 (14%)	8 (7%)	10 (9%)
MCS	113	89 (79%)	9 (8%)	7 (6%)	8 (7%)
MMM	107	105 (98%)	2 (2%)	0 (0%)	0 (0%)
PMC	108	105 (97%)	3 (3%)	0 (0%)	0 (0%)
Triple-S	117	109 (93%)	5 (4%)	1 (1%)	2 (2%)
Overall	**710**	**610 (86%)**	**40 (6%)**	**29 (4%)**	**31 (4%)**

A description of the content evaluated under each domain follows:

- Grievance System – The evaluation of the Grievance System included, but was not limited to, review of: policies and procedures for grievances and appeals, file review of member and provider grievances and appeals, MCO program reports on appeals and grievances, QI committee minutes, and staff interviews.
- Enrollee Rights and Protection – The evaluation in this area included, but was not limited to, review of: policies and procedures for member rights and responsibilities, PCP changes, documentation of advance medical directives and medical record keeping standards. Also reviewed were informational materials including the Member Handbook, processes for monitoring provider compliance with Advance Medical Directives and medical record keeping standards; and evidence of monitoring, evaluation, analysis, and follow up regarding Advance Medical Directives.
- Program Integrity *(new for 2015)* – The evaluation in this area included, but was not limited to, review of MCOs' policies and procedures, training programs, reporting and analysis; compliance with Annual Disclosure of Ownership (ADO) and financial interest provisions; and file review of program integrity cases.
- Quality Assessment and Performance Improvement (QAPI):Access – The evaluation of this area included, but was not limited to, review of: policies and procedures for direct access services; provider access requirements; program capacity reporting; case management and care coordination; utilization management; evidence of monitoring program capacity for primary care, specialists, hospital care, and ancillary services; as well as evidence of evaluation, analysis and follow up related to program capacity monitoring and the biannual audits of staff compliance with case management documentation requirements. Additionally, file review for case management and utilization management was conducted.
- Quality Assessment and Performance Improvement (QAPI):Measurement and Improvement – The evaluation in this area included, but was not limited to, review of: Quality Improvement (QI) Program Description, Annual QI Evaluation, QI Work Plan, QI Committee structure and function, including meeting minutes; Performance Improvement Projects (PIPs), HEDIS Final Audit Report, documentation related to performance measure calculation, reporting and follow up; and evidence of internal assessment of accuracy and completeness of encounter data.
- Quality Assessment and Performance Improvement (QAPI): Structure and Operations – The evaluation in this area included, but was not limited to, review of policies and procedures for excluded providers, credentialing and re-credentialing, enrollment and disenrollment, and tracking of disenrollment data. File review for credentialing and re-credentialing was conducted. Subcontractor contracts and oversight was also received.

File reviews were conducted for the following:

- Grievance File Review: Files were assessed for the following:
  - Completeness of documentation.
  - Timeliness of resolution.

- Format and content of communications to the enrollee.
- Use of appropriately qualified clinical staff to conduct reviews.

- Appeals File Review: Files were assessed for the following:
  - Completeness of documentation.
  - Timeliness of resolution.
  - Providing the enrollee/representative the opportunity to present evidence.
  - Providing the enrollee/representative the opportunity to examine the case file.
  - Including required parties as party to the appeal.
  - Timeliness of resolution for both standard and expedited appeals.
  - Provision of notice of action to the enrollee – oral and/or written.
  - Format and content of written notices to the enrollee.
  - Use of appropriately qualified clinical staff to conduct reviews.

- Utilization Management File Review: Files were assessed for the following:
  - Completeness of documentation.
  - Format and content of written notices to the enrollee.
  - Use of language to ensure ease of understanding for the enrollee.
  - Clear statement of the MCO action to be taken.
  - Clear statement of the reason for the MCO action.
  - Inclusion of the enrollee/provider right to file an appeal with the MCO, the right to request a State Fair Hearing, and process for requests.
  - Notice to the enrollee of circumstances for expedited resolution and how to request it.
  - Notice the enrollee of the right to continue benefits pending resolution, and the possibility of financial responsibility.
  - Timeliness of resolution.
  - Use of appropriately qualified clinical staff to conduct reviews.

- QAPI: Access - Care Management File Review: Files were assessed for the following:
  - Collaborative development of the case management plan.
  - Assessment of member needs.
  - Identification of goals and interventions.
  - Monitoring of progress.

The following section summarizes the 2016 Medicaid Compliance Review findings for each plan and provides a description of each of the elements found to be minimally compliant or non-compliant.

Constellation 2016 Medicare Compliance Review Findings for Contract Year 2015

A summary of the Medicare compliance results for Constellation is provided below. For each standard, the following is provided: current year overall category compliance designations; and a description of the current year findings for all standards/elements found minimally or non-compliant.

Table 17: Constellation – Summary of 2016 Medicare Compliance Review Findings

Constellation: Summary of 2016 Medicare Managed Care Compliance Review Findings (Review Year 2015)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	20	10	1	9	0
Enrollee Rights and Protections					
Program Integrity	92	86	2	1	3

Constellation: Summary of 2016 Medicare Managed Care Compliance Review Findings (Review Year 2015)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Quality Assessment and Performance Improvement (QAPI) – Access	9	5	2	0	2
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	8	8	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	23	14	0	3	6
Total #/ (% of Total)	**152**	**123 (81%)**	**5 (3%)**	**13 (9%)**	**11 (7%)**

Table 18: Constellation – 2016 Medicare Compliance Review: Minimal and Non-Compliant Elements

Constellation: 2016 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	• Notice of Action: (a) *Language and format requirements.* The notice must be in writing and must meet the language and format requirements of §438.10(c) and (d) to ensure ease of understanding. **Minimal Compliance:** UM files should contain the notice of action/denial letter and be written in a format and language that is easily understood by the member. • The notice must explain the following: **(2)** The reasons for the action. **Minimal Compliance:** UM files should include the action taken. **(3)** The enrollee's or the provider's right to file an MCO or PIHP appeal. **Minimal Compliance:** UM files should include the member's right to file an appeal in the notice of action. **(4)** If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing. **Minimal Compliance:** UM files should include the member's right to request a State fair hearing. **(5)** The procedures for exercising the rights specified in this paragraph. **Minimal Compliance:** UM files should include the member's right to request a State fair hearing and the procedure to request it. **(6)** The circumstances under which expedited resolution is available and how to request it. **Minimal Compliance:** UM files should include the circumstances under which expedited resolution is available and how to request it. **(7)** The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services. **Minimal Compliance:** UM files should include the enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services. • In handling grievances and appeals, each MCO and each PIHP must meet the following requirements: **(2)** Acknowledge receipt of each grievance and

Constellation: 2016 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
	appeal. **Minimal Compliance:** All grievance policies should consistently address issuance of an acknowledgment letter including the circumstances for issuing a letter and a timeframe for doing so. Per the MCO's existing policy, an acknowledgment letter should be sent for all written grievance requests and for appeal requests. A copy of the letter should be maintained in the respective file. • Resolution and notification: Grievances and appeals. (d) *Format of notice.* (1) Grievances. The State must establish the method the MCOs and PIHPs will use to notify an enrollee of the disposition of a grievance. **Minimal Compliance:** Resolution notices should be responded to in writing.
Program Integrity	• Include a monitoring program that is designed to prevent and detect potential or suspected Fraud and Abuse. This monitoring program shall include but not be limited to: (4) verifying with enrollees the delivery of services as claimed; **Non-Compliance:** Documentation addressing this was not found. • At a minimum, the Contractor shall include in each report, with respect to individual investigations of Fraud, Abuse, or Waste: f. All communication between the Contractor and the provider about the complaint; **Non-Compliance:** No PI files were presented. MCO stated there were no cases. j. Contact information for a Contractor staff person with relevant knowledge of the matter. **Non-Compliance:** No PI files were presented. MCO stated there were no cases. • Each company must submit to the Compliance Office a certification signed by the Compliance Director and the President or CEO indicating that all full investigations were made in accordance with 42 CFR 455.15. **Minimal Compliance:** The plan should add the requirement language to a policy or procedure.
Quality Assessment and Performance Improvement (QAPI) – Access	• Specify what constitutes "medically necessary services" in a manner that— (i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and (ii) Addresses the extent to which the MCO is responsible for covering services related to the following: (A) The prevention, diagnosis, and treatment of health impairments, (B) The ability to achieve age-appropriate growth and development,(C) The ability to attain, maintain, or regain functional capacity. **Non-Compliance:** Policy CLIN-001 organization Determination was provided but does not address the requirements of this section. • *Compensation of utilization management activities*. Each contract must provide that, consistent with §438.6(h) and §422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee. **Non-Compliance:** No documentation was provided that addressed this requirement.
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	• All applicable requirements were Compliant.*

Constellation: 2016 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	• *Adoption of practice guidelines*. Each MCO adopts practice guidelines that meet the following requirements: (2) Consider the needs of the MCO's enrollees. **Non-Compliance:** As noted last year, the plan should describe its process for assessing member needs in order to identify areas needing development or adoption of guidelines. • *Adoption of practice guidelines*. Each MCO adopts practice guidelines that meet the following requirements: (3) Are adopted in consultation with contracting health care professionals. **Minimal Compliance:** The plan should develop a policy or procedure that describes how physician input is included in their processes. The plan should maintain agendas and minutes for its QIC meetings. • Quality Assessment and Performance Improvement Program: (1) The State must require, through its contracts that each MCO have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees, and (2) CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by States in their contracts with MCOs. **Minimal Compliance:** As noted last year, Constellation Health should develop an annual QI Work Plan that includes yearly planned activities and related actions objectives for each activity, the timeframe for completing each activity and the responsible party assigned to the activity. The Work Plan should allow for periodic updates to document progress in achieving each activity. The scope of the Work Plan should include, but not be limited to: activities planned for the year (such as CCIP and QIP projects, performance measure reporting, CAHPS, HOS, MOC, monitoring compliance with practice guidelines), monitoring of previously identified issues, conduct of the annual QI program evaluation and annual review of the QI Program Description, other activities related to STARS reporting, monitoring of grievances, and Part C and D reporting. The QI Committee should meet as planned and the roles and responsibilities of the committee should be clearly defined in the QAPI Program Description. Responsibilities should include recommending policy decisions, discussing and analyzing results of QI activities including review of the progress of the annual QI Work Plan, and recommending actions and follow-up as necessary. Agenda topics should include reports from relevant departments such as QI, care management, UM, grievances and member services. Action and follow-up items determined in one meeting should be followed through in subsequent meetings until completed. Meeting minutes should reflect the committee's carrying out of its responsibilities as defined in the QAPI Program Description. • The State must review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. **Non-Compliance:** Constellation did not submit an annual program evaluation. • The State must review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The review must include (i) The MCO's performance on the standard measures on which it is required to report; **Non-Compliance:** Constellation did not submit an annual program evaluation. • The State must review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The

Constellation: 2016 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
	review must include (ii) The results of each MCO's performance improvement projects. **Non-Compliance:** Constellation did not submit an annual program evaluation. • The State may require that an MCO have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. **Non-Compliance:** Constellation did not submit an annual program evaluation. • *Basic elements of a health information system.* The State must require, at a minimum, that each MCO comply with the following: (1) Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State. **Non-Compliance:** Constellation did not provide screen shots as was provided last year, nor did the plan provide policies/procedures for collecting and processing claims and encounter data. • Ensure that data received from providers is accurate and complete by collecting service information in standardized formats to the extent feasible and appropriate. **Non-Compliance:** Constellation did not provide screen shots as was provided last year, nor did the plan provide policies/procedures for collecting and processing claims and encounter data.

*Compliance is defined as having Full or Substantial Compliance.

Humana Health Plan (HHP) 2016 Medicare Compliance Review Findings for Contract Year 2015

A summary of the Medicare compliance results for Humana Health Plan is provided below. For each standard, the following is provided: current year overall category compliance designations and a description of the current year findings for all standards/elements found minimally or non-compliant.

Table 19: Humana – Summary of 2016 Medicare Compliance Review Findings

Humana Health Plan: Summary of 2016 Medicare Managed Care Compliance Review Findings (Review Year 2015)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System					
Enrollee Rights and Protections					
Program Integrity	92	70	4	8	10
Quality Assessment and Performance Improvement (QAPI) – Access	3	3	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations					
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	18	6	12	0	0
Total #/ (% of Total)	**113**	**79 (70%)**	**16 (14%)**	**8 (7%)**	**10 (9%)**

Table 20: Humana – 2016 Medicare Compliance Review: Minimal and Non-Compliant Elements

Humana Health Plan: 2016 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Program Integrity	• Ensure that providers and enrollees are educated about Fraud and Abuse identification and reporting in provider and enrollee materials; **Minimal Compliance:** Humana should ensure that enrollees are educated about fraud and abuse identification and reporting in their enrollee materials and Enrollee Handbook. • The Contractor shall include in the Enrollee Handbook instructions on how to report Fraud and Abuse and the protections for whistleblowers. **Minimal Compliance:** Missing from the documentation is evidence in the Enrollee Handbook that the plan instructs its enrollee on how to report fraud and abuse and the protections for whistleblowers. • At a minimum, the Contractor shall include in each report, with respect to individual investigations of Fraud, Abuse, or Waste: - Enrollee name and ID number; - Provider name and NPI; - Type of provider; - Date of the complaint; - Contact information for a Contractor staff person with relevant knowledge of the matter; **Minimal Compliance:** It is recommended that Humana develop a procedure that includes the above items required in the investigation reports. • The Contractor shall also include in the report a summary (not specific to an individual case) of: a. Investigative activities, corrective actions, prevention efforts, and results; and b. Trending and analysis of utilization management and provider payment management. **Non-Compliance:** The Plan did not submit any documentation for review that addressed the requirement. • The Contractor shall report to ASES, within (1) one business day of obtaining knowledge with respect to the identity of any provider or other person who, in violation of 42 CFR 438.610 (a) and (b), is debarred, suspended, or otherwise prohibited from participating in procurement activities. ASES shall promptly notify the Secretary of HHS of the noncompliance, as required by 42 CFR 438.610(c). **Non-Compliance:** The Plan did not submit any documentation for review that addressed the requirement. • Each company must submit to the Compliance Office a certification signed by the Compliance Director and the President or CEO indicating that all full investigations were made in accordance with 42 CFR 455.15. **Minimal Compliance:** It is recommended that Humana add this requirement to its policies and procedures. • Each Company has five (5) days to notify ASES about any adverse or negative action that the MCO has taken on provider application (upon initial application or application renewal) or actions which limit the ability of providers to participate in the program. **Non-Compliance:** No documentation was provided that shows that the plan was in compliance during the review period. • Each Company should develop and implement procedures to report to HHS-OIG and ASES within 20 working days any criminal conviction disclosures made during the MCO credentialing process. Copy of the

Humana Health Plan: 2016 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
	policies should be submitted to ASES Compliance Office. **Non-Compliance:** The plan did not submit documentation that contains the requirement for reporting within 20 days to HHS-OIG and ASES. • Each Company must submit to the Compliance Office a certification signed by the Compliance Director and the President or CEO stating compliance with 42 CFR 455.106. **Non-Compliance:** Missing from the plan's documentation is evidence of this requirement in a policy or procedure or evidence that the plan submits a certification to the Compliance Office that it obtains the required disclosures from providers. • Each Company must comply with requirement in 42 CFR 455.101. **Non-Compliance:** The Plan did not submit any documentation for review that addressed the requirement. Notice of withholding. The organization must send notice of its withholding of program payments within 5 days of taking such action. The notice must set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning its ongoing investigation. The notice must: (1) State that payments are being withheld in accordance with this provision; (2) State that the withholding is for a temporary period, and cite the circumstances under which withholding will be terminated; (3) Specify, when appropriate, to which type or types of payment (capitation or claims) withholding is effective; and (4) Inform the provider of the right to submit written evidence for consideration by the agency. **Non-Compliance:** The Plan did not submit any documentation for review that addressed the requirement. • Duration of withholding. All withholding of payment actions under this section will be temporary and will not continue after: (1) The agency or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation bye the provider; or (2) Legal proceedings related to the provider's alleged fraud or willful misrepresentations are completed. **Non-Compliance:** The Plan did not submit any documentation for review that addressed the requirement. • The PIP must include withholding of payment processes and procedures to enforce above guideline. **Non-Compliance:** The Plan did not submit any documentation for review that addressed the requirement. • Notification to Inspector General.(1) The organization must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information. (2) The organization must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program. **Non-Compliance:** The Plan did not submit any documentation for review that addressed the requirement.
Quality Assessment and Performance Improvement (QAPI) – Access	• All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI)	• All applicable requirements were Compliant.*

Humana Health Plan: 2016 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
– Measurement and Improvement	

*Compliance is defined as having Full or Substantial Compliance.

Medical Card Systems (MCS) 2016 Medicare Compliance Review Findings for Contract Year 2015

A summary of the Medicare compliance results for MCS is provided below. For each standard, the following is provided: current year overall category compliance designations; and a description of the current year findings for all standards/elements found minimally or non-compliant.

Table 21: MCS – Summary of 2016 Medicare Compliance Review Findings

Medical Card Systems: Summary of 2016 Medicare Managed Care Compliance Review Findings (Review Year 2015)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	1	0	1	0	0
Enrollee Rights and Protections	2	1	1	0	0
Program Integrity	92	77	1	7	7
Quality Assessment and Performance Improvement (QAPI) – Access					
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	3	1	1	0	1
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	15	10	5	0	0
Total #/ (% of Total)	**113**	**89 (79%)**	**9 (8%)**	**7 (6%)**	**8 (7%)**

Table 22: MCS – 2016 Medicare Managed Care Compliance Review: Minimal and Non-Compliant Elements

Medical Card Systems: 2016 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	• All applicable requirements were Compliant.*
Enrollee Rights and Protections	• All applicable requirements were Compliant.*
Program Integrity	• The Contractor shall include in the Enrollee Handbook instructions on how to report Fraud and Abuse and the protections for whistleblowers. **Minimal Compliance:** It is recommended that the plan add the requirement to its policies and procedures. • At a minimum, the Contractor shall include in each report, with respect to individual investigations of Fraud, Abuse, or Waste: ○ All communication between the Contractor and the provider about the complaint; ○ Date of the complaint; **Minimal Compliance:** The plan should add these two requirements to its policies and procedures.

Medical Card Systems: 2016 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
	• The Contractor shall also include in the report a summary (not specific to an individual case) of: a. Investigative activities, corrective actions, prevention efforts, and results; and b. Trending and analysis of utilization management and provider payment management. **Non-Compliance:** No documentation was submitted that fulfills this requirement. • The Contractor shall report to ASES, within (1) one business day of obtaining knowledge with respect to the identity of any provider or other person who, in violation of 42 CFR 438.610 (a) and (b), is debarred, suspended, or otherwise prohibited from participating in procurement activities. ASES shall promptly notify the Secretary of HHS of the noncompliance, as required by 42 CFR 438.610(c). **Non-Compliance:** No documentation was submitted that fulfills this requirement. • Each Company has five (5) days to notify ASES about the referrals made to the US Attorney's Field Office and HHS-OIG. **Minimal Compliance:** The plan should add the five day requirement to its policy. • Each company must submit to the Compliance Office a certification signed by the Compliance Director and the President or CEO indicating that all full investigations were made in accordance with 42 CFR 455.15. **Non-Compliance:** The Plan did not submit any evidence of signed certifications that were submitted to the Compliance Office as per the requirement. • Each Company has five (5) days to notify ASES about any adverse or negative action that the MCO has taken on provider application (upon initial application or application renewal) or actions which limit the ability of providers to participate in the program. **Non-Compliance:** No documentation was submitted that fulfills this requirement. • Each Company should develop and implement procedures to report to HHS-OIG and ASES within 20 working days any criminal conviction disclosures made during the MCO credentialing process. Copy of the policies should be submitted to ASES Compliance Office. **Minimal Compliance:** The plan should add the requirement, in its entirety, to a policy or procedure. • Each Company must submit to the Compliance Office a certification signed by the Compliance Director and the President or CEO stating compliance with 42 CFR 455.106. **Non-Compliance:** This requirement is not addressed in the plan's policies or procedures. No evidence of a certification signed by the Compliance Director and the President or CEO was included in the plan's documentation. • Each Company must comply with requirement in 42 CFR 455.20 and must document in a quarterly report compliance with regulation. **Minimal Compliance:** The plan should add the requirement, in its entirety, to a policy or procedure. • The organization will select a sample to perform independent reviews to verify that recipient's services billed by providers (as well as encounters under capitated environment) were indeed rendered. This review will be performed through confirmations to beneficiaries. **Non-Compliance:** The submitted documentation does not reference a specific methodology for sampling members to confirm member receipt of services from providers.

Medical Card Systems: 2016 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
	• The PIP must include withholding of payment processes and procedures to enforce above guideline. **Non-Compliance:** Unable to find documentation related to withholding of payments. • Notification to Inspector General.(1) The organization must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information. (2) The organization must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program**. Minimal Compliance:** The plan should add the requirement, in its entirety, to its policies and procedures.
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	• Cause for disenrollment. The following are cause for disenrollment: (i) The enrollee moves out of the MCO's service area. (ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks. (iii) The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk. (iv) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs**. Non-Compliance:** Disenrollment and Policy OP-ENCL-027 MA, MAPD Voluntary Disenrollment and Procedures should be updated to include the required language.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	• All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

MMM Medicare Compliance Review Findings for Contract Year 2016

A summary of the Medicare compliance results for MMM is provided below. For each standard, the following is provided: current year overall category compliance designations and a description of the current year findings for all standards/elements found minimally or non-compliant.

Table 23: MMM – Summary of 2016 Medicare Managed Care Compliance Review Findings

MMM: Summary of 2016 Medicare Managed Care Compliance Review Findings (Review Year 2015)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System					
Enrollee Rights and Protections					
Program Integrity	92	90	2	0	0
Quality Assessment and Performance Improvement (QAPI) – Access					

Quality Assessment and Performance Improvement (QAPI) – Structure and Operations					
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	15	15	0	0	0
Total #/ (% of Total)	**107**	**105 (98%)**	**2 (2%)**	**0 (0%)**	**0 (0%)**

Table 24: MMM – 2016 Medicare Compliance Review: Minimal and Non-Compliant Elements

MMM: 2016 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Program Integrity	• All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) –Measurement and Improvement	• All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

PMC 2016 Medicare Compliance Review Findings for Contract Year 2015

A summary of the Medicare compliance results for PMC is provided below. For each standard, the following is provided: current year overall category compliance designations; and a description of the current year findings for all standards/elements found minimally or non-compliant.

Table 25: PMC – Summary of 2016 Medicare Managed Care Compliance Review Findings

PMC: Summary of 2016 Medicare Managed Care Compliance Review Findings (Review Year 2015)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	1	0	1	0	0
Enrollee Rights and Protections					
Program Integrity	92	90	2	0	0
Quality Assessment and Performance Improvement (QAPI) – Access					
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations					
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	15	15	0	0	0
Total #/ (% of Total)	**108**	**105 (97%)**	**3 (3%)**	**0 (0%)**	**0 (0%)**

Table 26: PMC – 2016 Medicare Managed Care Compliance Review: Minimal and Non-Compliant Elements

PMC: 2016 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	• All applicable requirements were Compliant.*
Program Integrity	• All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	• All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

Triple-S 2016 Medicare Compliance Review Findings for Contract Year 2015

A summary of the Medicare compliance results for Triple-S is provided below. For each standard, the following is provided: current year overall category compliance designations; and a description of the current year findings for all standards/elements found minimally or non-compliant.

Table 27: Triple-S – Summary of 2016 Medicare Managed Care Compliance Review Findings

Triple-S: Summary of 2016 Medicare Managed Care Compliance Review Findings (Review Year 2015)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	3	2	1	0	0
Enrollee Rights and Protections	2	2	0	0	0
Program Integrity	92	89	0	1	2
Quality Assessment and Performance Improvement (QAPI) – Access					
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	2	2	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	18	14	4	0	0
Total #/ (% of Total)	**117**	**109 (93%)**	**5 (4%)**	**1 (1%)**	**2 (2%)**

Table 28: Triple-S – 2016 Medicare Managed Care Compliance Review: Minimal and Non-Compliant Elements

Triple-S: 2016 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	• All applicable requirements were Compliant.*
Enrollee Rights and Protections	• All applicable requirements were Compliant.*
Program Integrity	• Sixty (60) days after the date of the agreement the Company must submit to ASES Compliance Office copy of the policies and procedures for identifying and tracking potential provider fraud cases, for conducting preliminary and full investigation and for referring cases of suspected fraud to an appropriate law enforcement agency. The Compliance Plan should be developed in accordance with 42 CFR 438.608. **Minimal Compliance:** The plan should add the contract language into a policy or procedure. • The PIP must define the mechanism to monitor frequency of encounters and services rendered to patients billed by providers. **Non-Compliance:** This requirement is not found in the Program Integrity Plan (PIP). • The organization will select a sample to perform independent reviews to verify that recipient's services billed by providers (as well as encounters under capitated environment) were indeed rendered. This review will be performed through confirmations to beneficiaries. **Non-Compliance:** This requirement is missing from a policy or procedure.
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	• All applicable requirements were Compliant.*

Triple-S: 2016 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2015)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	• All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

IV. Performance Measures

This section of the report summarizes the Medicaid MCOs and Platino plans reporting of select performance measures.

PRHIA Requirements for Performance Measure Reporting

The 42 CFR §438.358(b)(2) establishes that one of the mandatory EQR activities for the Medicaid Managed Care health plans is the validation of performance measures reported (as required by the State) during the preceding 12 months. These are defined, in §438.240(b)(2), as any rational performance measures and levels that may be identified and developed by CMS in consultation with the states and other relevant stakeholders.

The PRHIA selected the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee of Quality Assurance (NCQA) as the required performance measures. PRHIA provided Medicaid plans with information on which HEDIS 2017 (measurement year 2016) and HEDIS 2016 (MY 2015) measures to report. The health plans were required to submit their final rates to IPRO, the Commonwealth's licensed HEDIS organization.

HEDIS 2016, 2017 Compliance Audit

HEDIS reporting is a contract requirement for Puerto Rico's Medicaid plans. The plans' HEDIS measure calculation is audited by an NCQA-licensed audit organization, in accordance with NCQA's HEDIS Compliance Audit specifications.

As part of the HEDIS 2016, 2017 Compliance Audit, auditors assessed compliance with NCQA standards in the seven designated Information Systems (IS) categories, as follows:

- IS 1.0: Medical Services Data - Sound Coding Methods and Data Capture, Transfer and Entry
- IS 2.0: Enrollment Data – Data Capture, Transfer and Entry
- IS 3.0: Practitioner Data – Data Capture, Transfer and Entry
- IS 4.0: Medical Record Review Process – Training, Sampling, Abstraction and Oversight
- IS 5.0: Supplemental Data – Capture, Transfer and Entry
- IS 6.0: Member Call Center Data – Capture, Transfer and Entry
- IS 7.0: Data Integration – Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

For HEDIS 2016 IPRO only audited MMM/PMC Medicaid and Triple S Medicaid. First Medical and Molina had already contracted with an audit firm since their contract with ASES required a HEDIS audit and the IPRO contract with ASES had not been signed at that point.

IPRO was not the audit firm for HEDIS 2017 but has reviewed the HEDIS 2017 audit reports provided by each MCO audited by a certified HEDIS vendor and is satisfied that the appropriate procedures were followed.

Triple-S did not submit HEDIS 2017 data to IPRO. PRHIA contacted plans on 2/7/2017 informing them which HEDIS 2017 measures were reportable. Triple-S acknowledges receipt of this letter but report that they were not provided any further details regarding the timeframe for submission of HEDIS data as indicated in the PRHIA letter.

Description of Performance Measures

The following HEDIS measures were reported. Descriptions are taken from the HEDIS 2017 technical specifications.

Effectiveness of Care: Prevention and Screening

Adult BMI Assessment (ABA)

The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year:

- BMI percentile documentation.
- Counseling for nutrition.
- Counseling for physical activity.

Childhood Immunization Status (CIS)

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

Breast Cancer Screening (BCS)

The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

Cervical Cancer Screening (CCS)

The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every 3 years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Colorectal Cancer Screening (COL) – Platino only

The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Chlamydia Screening in Women (CHL)

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Effectiveness of Care: Respiratory Conditions

Medication Management for People with Asthma (MMA)

The percentage of members 5–85 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.
2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) – Platino only

The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

Pharmacotherapy Management of COPD Exacerbation (PCE) – Platino only

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

Asthma Medication Ratio (AMR) – Platino only

The percentage of members 5–85 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Effectiveness of Care: Cardiovascular Conditions

Controlling High Blood Pressure (CBP)

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age whose BP was <140/90 mm Hg.
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

A single rate is reported and is the sum of all three groups

Persistence of Beta-Blocker Treatment after a Heart Attack (PBH) – Platino only

The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge

Statin Therapy for Patients with Cardiovascular Disease (SPC) – Platino only

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.

Effectiveness of Care: Diabetes

Comprehensive Diabetes Care (CDC)

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- HbA1c control (<7.0%) for a selected population.
- Eye exam (retinal) performed.
- Medical attention for nephropathy.
- BP control (<140/90 mm Hg).

Statin Therapy for Patients With Diabetes (SPD) – Platino only

The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Effectiveness of Care: Musculoskeletal

Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART) – Platino only

The percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).

Osteoporosis Management in Women Who Had a Fracture (OMW) – Platino only

The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

Effectiveness of Care: Behavioral Health

Antidepressant Medication Management (AMM)

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.

1. *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Follow-up Care for Children Prescribed ADHD Medication (ADD)

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

- *Initiation Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
- *Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Follow-up after Hospitalization for Mental Illness (FUH)

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days of discharge.
2. The percentage of discharges for which the member received follow-up within 7 days of discharge.

Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Platino only

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) – Platino only

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow up visit for AOD. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD)

The percentage of members 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Effectiveness of Care: Medication

Annual Monitoring for Patients on Persistent Medications (MPM) – Platino only

The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the three rates separately and as a total rate.

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).
- Annual monitoring for members on digoxin.
- Annual monitoring for members on diuretics.
- Total rate (the sum of the three numerators divided by the sum of the three denominators).

Medication Reconciliation Post-Discharge (MRP) – Platino only

The percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

Medication Management: Overuse/Appropriateness

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

Non-Recommended PSA-Based Screening in Older Men (PSA)[3] – Platino only

[3] A lower rate indicates better performance.

The percentage of men 70 years and older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA)-based screening.

Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)[3] – Platino only

The percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis.

Report each of the three rates separately and as a total rate.

- A history of falls and a prescription for anticonvulsants, SSRIs, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics or tricyclic antidepressants.
- Dementia and a prescription for antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants, H_2 receptor antagonists or anticholinergic agents.
- Chronic kidney disease and prescription for Cox-2 selective NSAIDs or non-aspirin NSAIDs.
- Total rate (the sum of the three numerators divided by the sum of the three denominators).

Members with more than one disease or condition may appear in the measure multiple times (i.e., in each indicator for which they qualify). A lower rate represents better performance for all rates.

Use of High-Risk Medications in the Elderly (DAE)[3] – Platino only

The percentage of Medicare members 66 years of age and older who had at least one dispensing event for a high-risk medication.

The percentage of Medicare members 66 years of age and older who had at least two dispensing events for the same high-risk medication.

Access/Availability of Care

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.

- Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.
- Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

Initiation and Engagement of AOD Dependence Treatment (IET) – Platino only

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.

- *Initiation of AOD Treatment.* The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- *Engagement of AOD Treatment.* The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Children and Adolescents' Access to Primary Care Practitioners (CAP)

The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.

- Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.
- Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Annual Dental Visit (ADV)

The percentage of members 2–20 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the organization's Medicaid contract.

Prenatal and Postpartum Care (PPC)

The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.
- *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Utilization

Frequency of Prenatal Care (FPC)

The percentage of Medicaid deliveries on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits:

- <21 percent of expected visits.
- 21 percent–40 percent of expected visits.
- 41 percent–60 percent of expected visits.
- 61 percent–80 percent of expected visits.
- ≥81 percent of expected visits.

This measure uses the same denominator as the *Prenatal and Postpartum Care* measure.

Well-Child Visits in the First 15 Months of Life (W15)

The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life:

- No well-child visits.
- One well-child visit.
- Two well-child visits.
- Three well-child visits.
- Four well-child visits.
- Five well-child visits.
- Six or more well-child visits.

Adolescent Well-Care Visits (AWC)

The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Frequency of Selected Procedures (FSP)

This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization.

Ambulatory Care (AMB)

This measure summarizes utilization of ambulatory care in the following categories:

- Outpatient Visits.
- ED Visits.

Identification of Alcohol and Other Drug Services (IAD)

This measure summarizes the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year:

- Any service.
- Inpatient.
- Intensive outpatient or partial hospitalization.
- Outpatient or ED.

Mental Health Utilization (MPT)

The number and percentage of members receiving the following mental health services during the measurement year:

- Any service.
- Inpatient.
- Intensive outpatient or partial hospitalization.
- Outpatient or ED.

Medicaid HEDIS 2017

The following table reports HEDIS 2017measures for Medicaid plans. When available a single rate is reported for each plan. If plans only supplied HEDIS 2017 data by region/product, HEDIS rates are reported by region/product.

Rates highlighted in green are at or above[4] the 2017 NCQA Medicaid national average[5]. Reasons for missing rates are indicated using the following:

- NR = not reported by plan. If the plan did not specify a reason for not reporting a measure they received an NR.
- N/A = not reported because of a small denominator (n < 30).
- BR = biased rate

[4] If a low rate is desirable it is noted in the table. For these measures, rates are highlighted if they are at or below the NCQA national average.

[5] Comparison is made with NCQA national average category 'All LOBs Excluding PPOs and EPO' [892].

Table 29. HEDIS 2017 Medicaid

HEDIS 2017 Measure/Data Element	First Medical - North	First Medical - San Juan	First Medical - Virtual	MMM - NE	MMM - SE	Molina	Triple-S
Effectiveness of Care: Prevention and Screening							
Adult BMI Assessment (ABA)							
Rate	11.1%	12.3%	2.0%	16.0%	23.0%	59.8%	NR
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)							
BMI Percentile (3-11 years)	NR	NR	NR	13.0%	11.0%	NR	NR
BMI Percentile (12-17 years)	NR	NR	NR	17.0%	8.0%	NR	NR
BMI Percentile (total)	6.2%	6.5%	4.5%	14.4%[2]	9.9%[2]	47.0%	NR
Counseling for Nutrition (3-11 years)	NR	NR	NR	3.0%	1.0%	NR	NR
Counseling for Nutrition (12-17 years)	NR	NR	NR	4.0%	3.0%	NR	NR
Counseling for Nutrition (total)	1.8%	8.1%	3.0%	3.4%[2]	1.8%[2]	44.6%	NR
Counseling for Physical Activity (3-11 years)	NR	NR	NR	1.0%	0.0%	NR	NR
Counseling for Physical Activity (12-17 years)	NR	NR	NR	1.0%	0.0%	NR	NR
Counseling for Physical Activity (total)	0.0%	0.3%	0.0%	1.0%[2]	0.0%[2]	37.3%	NR
Childhood Immunization Status (CIS)							
DTaP	0.1%	22.5%	1.2%	23.0%	22.0%	70.7%	NR
IPV	1.7%	27.5%	2.4%	31.0%	28.0%	81.4%	NR
MMR	56.4%	73.7%	43.4%	61.0%	70.0%	89.6%	NR
HiB	7.6%	44.6%	3.6%	49.0%	45.0%	86.9%	NR
Hepatitis B	NR	NR	NR	3.0%	1.0%	67.6%	NR
VZV	56.6%	73.7%	41.0%	62.0%	72.0%	88.9%	NR
Pneumococcal Conjugate	0.5%	20.0%	0.0%	23.0%	21.0%	66.3%	NR
Hepatitis A	NR	NR	NR	74.0%	84.0%	90.5%	NR
Rotavirus	0.4%	18.1%	0.0%	13.0%	17.0%	45.7%	NR
Influenza	8.3%	8.8%	9.6%	5.0%	19.0%	29.9%	NR
Combination #2	0.0%	4.9%	1.2%	1.0%	1.0%	57.0%	NR
Combination #3	0.0%	4.3%	0.0%	1.0%	0.0%	53.0%	NR
Combination #4	NR	NR	NR	1.0%	0.0%	NR	NR
Combination #5	NR	NR	NR	0.0%	0.0%	NR	NR
Combination #6	NR	NR	NR	0.0%	0.0%	NR	NR

HEDIS 2017 Measure/Data Element	First Medical - North	First Medical - San Juan	First Medical - Virtual	MMM - NE	MMM - SE	Molina	Triple-S
Combination #7	NR	NR	NR	0.0%	0.0%	NR	NR
Combination #8	NR	NR	NR	0.0%	0.0%	NR	NR
Combination #9	NR	NR	NR	0.0%	0.0%	NR	NR
Combination #10	0.0%	0.8%	0.0%	0.0%	0.0%	15.5%	NR
Breast Cancer Screening (BCS)							
Rate	57.3%	50.2%	NR	61.9%	60.9%	69.9%	NR
Cervical Cancer Screening (CCS)							
Rate	34.7%	41.6%	0.0%	54.0%	57.0%	57.8%	NR
Chlamydia Screening in Women (CHL)							
16-20 Years	NR	NR	NR	56.4%	43.4%	NR	NR
21-24 Years	NR	NR	NR	53.7%	47.6%	NR	NR
Total	42.1%	58.3%	53.5%	54.8%[2]	45.9%[2]	47.7%	NR
Effectiveness of Care: Respiratory Conditions							
Medication Management for People With Asthma (MMA)							
≥ 50% treatment period (5-11 years)[1]	NR	NR	NR	49.0%	48.4%	NR	NR
≥ 50% treatment period (12-18 years)[1]	NR	NR	NR	46.0%	47.0%	NR	NR
≥ 50% treatment period (19-50 years) [1]	NR	NR	NR	59.6%	56.7%	NR	NR
≥ 50% treatment period (51-64 years) [1]	NR	NR	NR	68.0%	63.5%	NR	NR
≥ 50% treatment period (total)[1]	55.9%	64.4%	62.5%	57.3%[2]	55.1%[2]	62.7%	NR
≥ 75% treatment period (5-11 years)	NR	NR	NR	23.5%	21.4%	NR	NR
≥ 75% treatment period (12-18 years)	NR	NR	NR	25.0%	22.0%	NR	NR
≥ 75% treatment period (19-50 years)	NR	NR	NR	32.6%	28.7%	NR	NR
≥ 75% treatment period (51-64 years)	NR	NR	NR	44.0%	41.0%	NR	NR
≥ 75% treatment period (total)	33.2%	39.6%	37.5%	32.3%[2]	28.9%[2]	38.4%	NR
Effectiveness of Care: Cardiovascular Conditions							
Controlling High Blood Pressure (CBP)							
Rate	BR	BR	BR	0.0%	0.0%	44.4%	NR
Effectiveness of Care: Diabetes							
Comprehensive Diabetes Care (CDC)							
Hemoglobin A1c (HbA1c) Testing	75.0%	71.3%	81.8%	65.0%	71.0%	83.9%	NR
HbA1c Poor Control (>9.0%)[3]	99.6%	99.9%	100.0%	91.0%	95.0%	59.4%	NR
HbA1c Control (<8.0%)	0.3%	0.1%	0.0%	3.0%	2.0%	27.8%	NR

HEDIS 2017 Measure/Data Element	First Medical - North	First Medical - San Juan	First Medical - Virtual	MMM - NE	MMM - SE	Molina	Triple-S
HbA1c control (<7.0%) for a Selected Population	0.2%	0.0%	0.0%	3.0%	2.0%	BR	NR
Eye Exam	19.0%	23.9%	18.2%	19.0%	19.0%	40.6%	NR
Medical Attention for Nephropathy	NR	NR	NR	89.0%	91.0%	94.3%	NR
BP Control (<140/90 mmHG)	0.0%	0.0%	0.0%	14.0%	8.0%	50.3%	NR
Effectiveness of Care: Behavioral Health							
Antidepressant Medication Management (AMM)							
Acute	49.2%	51.0%	60.7%	48.5%	43.9%	52.5%	NR
Continuation	34.5%	37.6%	58.9%	33.9%	30.0%	40.4%	NR
Follow-up Care for Children Prescribed ADHD Medication (ADD)							
Initiation	48.5%	57.9%	48.7%	37.2%	47.6%	48.4%	NR
Continuation	64.6%	70.3%	54.2%	46.0%	58.0%	59.0%	NR
Follow-up After Hospitalization for Mental Illness (FUH)							
7 day	51.2%	50.0%	26.2%	30.8%	21.4%	29.3%	NR
30 day	70.1%	67.0%	46.7%	70.0%	65.2%	42.7%	NR
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD)							
Rate	62.8%	55.8%	73.1%	57.3%	69.0%	68.6%	NR
Medication Management: Overuse/Appropriateness							
Appropriate Treatment for Children With Upper Respiratory Infection (URI)							
Rate	77.4%	86.0%	77.6%	18.0%	29.9%	84.7%	NR
Access/Availability of Care							
Adults' Access to Preventive/Ambulatory Health Services (AAP)							
20-44 Years	69.6%[4]	66.9%[4]	63.5%	62.3%	66.0%	70.3%	NR
45-64 Years	82.9%	81.8%	NR	77.1%	78.0%	83.4%	NR
65+ Years	83.8%	82.6%	NR	58.7%	66.4%	83.8%	NR
Total	NR	NR	NR	67.4%[2]	70.5%[2]	NR	NR
Children and Adolescents' Access to Primary Care Practitioners (CAP)							
12-24 Months	86.4%	90.5%	89.4%	86.9%	88.8%	89.5%	NR
25 Months - 6 Years	81.2%	85.9%	82.7%	81.0%	84.3%	83.5%	NR
7-11 Years	82.7%	83.9%	82.9%	84.3%	86.7%	85.6%	NR
12-19 Years	77.1%	74.0%	79.8%	76.4%	79.9%	78.1%	NR
Annual Dental Visit (ADV)							

HEDIS 2017 Measure/Data Element	First Medical - North	First Medical - San Juan	First Medical - Virtual	MMM - NE	MMM - SE	Molina	Triple-S
2-3 years	NR	NR	NR	14.1%	16.9%	NR	NR
4-6 years	NR	NR	NR	20.8%	32.7%	NR	NR
7-10 years	NR	NR	NR	21.3%	32.1%	NR	NR
11-14 years	NR	NR	NR	18.5%	26.8%	NR	NR
15-18 years	NR	NR	NR	16.6%	24.6%	NR	NR
19-20 years	NR	NR	NR	13.7%	22.2%	NR	NR
Total	58.6%	59.4%	60.3%	18.1%[2]	26.7%[2]	54.4%	NR
Prenatal and Postpartum Care (PPC)							
Timeliness of Prenatal Care	81.1%	74.1%	52.9%	60.0%	34.0%	65.6%	NR
Postpartum Care	13.4%	24.1%	24.3%	21.0%	11.0%	18.3%	NR
Utilization[7]							
Frequency of Prenatal Care (FPC)[7]							
< 21 % of EV	NR	NR	NR	28.0%	74.0%	NR	NR
21-40% of EV	NR	NR	NR	13.0%	16.0%	NR	NR
41-60 % of EV	NR	NR	NR	10.0%	4.0%	NR	NR
61-80 % of EV	NR	NR	NR	12.0%	3.0%	NR	NR
≥ 81% of EV	52.0%	60.4%	28.6%	36.0%[5]	3.0%[5]	11.7%	NR
Well-Child Visits in the First 15 Months of Life (W15)[7]							
0 Visits	NR	NR	NR	31.0%	23.0%	NR	NR
1 Visit	NR	NR	NR	23.0%	22.0%	NR	NR
2 Visits	NR	NR	NR	18.0%	20.0%	NR	NR
3 Visits	NR	NR	NR	11.0%	13.0%	NR	NR
4 Visits	NR	NR	NR	7.0%	9.0%	NR	NR
5 Visits	NR	NR	NR	5.0%	6.0%	NR	NR
6+ Visits	BR	BR	BR	6.0%[6]	8.0%[6]	12.0%	NR
Adolescent Well-Care Visits (AWC)[7]							
Rate	13.8%	17.3%	15.5%	41.0%	47.0%	33.6%	NR
Frequency of Selected Procedures (FSP)[7]							
Bariatric weight loss surgery (0-19 years; male) per 1000 member months	0.0	0.0	0.0	NR	NR	0.0	NR

HEDIS 2017 Measure/Data Element	First Medical - North	First Medical - San Juan	First Medical - Virtual	MMM - NE	MMM - SE	Molina	Triple-S
Bariatric weight loss surgery (0-19 years; female) per 1000 member months	0.0	0.0	0.0	NR	NR	0.0	NR
Bariatric weight loss surgery (20-44 years; male) per 1000 member months	0.0	0.0	0.0	NR	NR	0.0	NR
Bariatric weight loss surgery (20-44 years; female) per 1000 member months	0.0	0.0	0.0	NR	NR	0.0	NR
Bariatric weight loss surgery (45-64 years; male) per 1000 member months	0.0	0.0	0.0	NR	NR	0.0	NR
Bariatric weight loss surgery (45-64 years; female) per 1000 member months	0.0	0.0	0.0	NR	NR	0.0	NR
Tonsillectomy (0-9 years) per 1000 member months	0.1	0.1	0.1	NR	NR	0.1	NR
Tonsillectomy (10-19 years) per 1000 member months	0.0	0.0	0.0	NR	NR	0.0	NR
Hysterectomy, abdominal (15-44 years) per 1000 member months	0.4	0.1	0.0	NR	NR	0.3	NR
Hysterectomy, abdominal (45-64 years) per 1000 member months	0.6	0.3	0.0	NR	NR	0.5	NR
Hysterectomy, vaginal (15-44 years) per 1000 member months	0.0	0.0	0.0	NR	NR	0.0	NR
Hysterectomy, vaginal (45-64 years) per 1000 member months	0.1	0.1	0.0	NR	NR	0.1	NR
Cholecystectomy, open (30-64 years; male) per 1000 member months	0.0	0.0	0.0	NR	NR	0.0	NR
Cholecystectomy, open (15-44 years; female) per 1000 member months	0.0	0.0	0.0	NR	NR	0.0	NR
Cholecystectomy, open (45-64 years; female) per 1000 member months	0.0	0.0	0.0	NR	NR	0.1	NR
Cholecystectomy, laparoscopic (30-64 years; male) per 1000 member months	0.3	0.3	0.0	NR	NR	0.3	NR

HEDIS 2017 Measure/Data Element	First Medical - North	First Medical - San Juan	First Medical - Virtual	MMM - NE	MMM - SE	Molina	Triple-S
Cholecystectomy, laparoscopic (15-44 years; female) per 1000 member months	0.7	0.5	0.5	NR	NR	0.6	NR
Cholecystectomy, laparoscopic (45-64 years; female) per 1000 member months	0.8	0.6	0.0	NR	NR	0.7	NR
Back Surgery (20-44; male) per 1000 member months	0.0	0.0	0.0	NR	NR	0.0	NR
Back Surgery (20-44; female) per 1000 member months	0.0	0.0	0.0	NR	NR	0.1	NR
Back Surgery (45-64; male) per 1000 member months	0.1	0.1	0.0	NR	NR	0.1	NR
Back Surgery (45-64; female) per 1000 member months	0.1	0.1	0.0	NR	NR	0.1	NR
Mastectomy (15-44; female) per 1000 member months	0.0	0.0	0.0	NR	NR	0.0	NR
Mastectomy (45-64; female) per 1000 member months	0.1	0.1	0.0	NR	NR	0.1	NR
Lumpectomy (15-44; female) per 1000 member months	0.2	0.1	0.1	NR	NR	0.1	NR
Lumpectomy (45-64; female) per 1000 member months	0.4	0.4	0.0	NR	NR	0.4	NR
Ambulatory Care (AMB)[7]	**Procedures per 1000 member months**						
Outpatient visits per 1000 member months	292.9	292.0	267.5	NR	NR	252.2	NR
ED visits per 1000 member months	105.0	92.2	119.1	NR	NR	105.1	NR
Identification of Alcohol and Other Drug Services (IAD)[7]							
Any chemical dependency service	1.4%	2.5%	4.3%	NR	NR	1.3%	NR
Inpatient chemical dependency service	0.2%	0.6%	0.1%	NR	NR	0.3%	NR
Intensive outpatient or partial hospitalization chemical dependency service	0.0%	0.0%	0.0%	NR	NR	0.0%	NR

HEDIS 2017 Measure/Data Element	First Medical - North	First Medical - San Juan	First Medical - Virtual	MMM - NE	MMM - SE	Molina	Triple-S
Outpatient or ED chemical dependency service	1.3%	2.1%	4.2%	NR	NR	1.1%	NR
Mental Health Utilization (MPT)[7]							
Any mental health service	11.4%	13.2%	54.2%	NR	NR	9.0%	NR
Inpatient mental health service	0.3%	0.5%	2.6%	NR	NR	0.8%	NR
Intensive outpatient or partial hospitalization mental health service	0.2%	0.2%	0.4%	NR	NR	0.4%	NR
Outpatient or ED mental health service	11.3%	13.1%	54.0%	NR	NR	8.8%	NR

[1] NCQA average not available for this measure.
[2] Total rates calculated by IPRO. MMM did not report total rates for these measures, but did report numerators and denominators allowing IPRO to calculate a total rate.
[3] A lower rate indicates better performance.
[4] First Medical reported age cohort as 20 – 40. First Medical correctly reports the next age cohort as 45 – 64.
[5] MMM reported rate as > 81% (measure is ≥ 81%).
[6] MMM reported 6 visits for FPC (measure is 6+).
[7] Rates for utilization measures are not compared to NCQA average. From the HEDIS specifications: "NCQA does not view higher or lower service counts as indicating better or worse performance."

Medicaid HEDIS 2016

The following table reports HEDIS 2016 measures for Medicaid plans. When available a single rate is reported for each plan. If plans only supplied HEDIS 2016 data by region/product, HEDIS rates are reported by region/product.

Rates highlighted in green are at or above[6] the 2016 NCQA Medicaid national average[7]. Reasons for missing rates are indicated using the following:

- NR = not reported by plan. If the plan did not specify a reason for not reporting a measure they received an NR.
- N/A = not reported because of a small denominator (n < 30).
- BR = biased rate

Table 30: HEDIS 2016 Medicaid

HEDIS 2016 Measure/Data Element	First Medical	MMM-NE	PMC	Molina	Triple-S (Metro North)	Triple-S (West)
Effectiveness of Care: Prevention and Screening						
Adult BMI Assessment (ABA)						
Rate	N/A	56.2%	65.9%	49.2%	60.1%	64.0%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						

[6] If a low rate is desirable it is noted in the table. For these measures, rates are highlighted if they are at or below the NCQA national average.
[7] Comparison is made with NCQA national average category 'All LOBs Excluding PPOs and EPO' [892].

HEDIS 2016 Measure/Data Element	First Medical	MMM-NE	PMC	Molina	Triple-S (Metro North)	Triple-S (West)
BMI Percentile (3-11 years)	NR	20.4%	45.7%	NR	45.2%	34.7%
BMI Percentile (12-17 years)	NR	17.6%	43.2%	NR	44.0%	36.7%
BMI Percentile (total)	1.7%	19.5%	44.8%	23.8%	44.8%	35.3%
Counseling for Nutrition (3-11 years)	NR	51.1%	53.6%	NR	48.5%	26.5%
Counseling for Nutrition (12-17 years)	NR	38.9%	52.7%	NR	51.1%	32.5%
Counseling for Nutrition (total)	1.9%	47.2%	53.3%	30.5%	49.4%	28.2%
Counseling for Physical Activity (3-11 years)	NR	44.6%	46.0%	NR	40.0%	24.7%
Counseling for Physical Activity (12-17 years)	NR	38.2%	45.9%	NR	49.7%	31.7%
Counseling for Physical Activity (total)	0.0%	42.6%	46.0%	21.6%	43.3%	26.8%
Childhood Immunization Status (CIS)						
DTaP	4.3%	60.8%	75.9%	23.2%	71.5%	74.2%
IPV	7.1%	73.5%	85.2%	27.6%	84.4%	84.7%
MMR	34.0%	85.4%	88.8%	64.4%	85.6%	90.3%
HiB	10.7%	72.3%	85.9%	47.8%	87.4%	88.1%
Hepatitis B	2.5%	44.3%	62.5%	7.9%	60.6%	62.5%
VZV	28.9%	74.9%	84.4%	60.8%	82.0%	86.1%
Pneumococcal Conjugate	4.6%	56.2%	68.1%	22.7%	59.6%	66.4%
Hepatitis A	59.9%	86.4%	90.3%	74.7%	86.6%	86.9%
Rotavirus	4.1%	45.5%	52.8%	15.8%	56.5%	58.6%
Influenza	2.5%	11.0%	12.7%	6.4%	11.4%	12.2%
Combination #2	1.3%	34.1%	53.3%	4.2%	45.3%	49.6%
Combination #3	1.3%	31.4%	47.7%	4.1%	38.9%	44.8%
Combination #4	1.3%	31.4%	47.7%	NR	38.2%	43.8%
Combination #5	1.0%	22.4%	32.1%	NR	30.7%	32.6%
Combination #6	0.0%	5.4%	9.3%	NR	8.8%	8.3%
Combination #7	1.0%	22.4%	32.1%	NR	29.9%	32.1%
Combination #8	0.0%	5.4%	9.3%	NR	8.8%	8.0%
Combination #9	0.0%	2.4%	7.3%	NR	7.3%	7.5%
Combination #10	0.0%	2.4%	7.3%	0.3%	7.3%	7.3%
Breast Cancer Screening (BCS)						

HEDIS 2016 Measure/Data Element	First Medical	MMM-NE	PMC	Molina	Triple-S (Metro North)	Triple-S (West)
Rate	N/A	N/A	N/A	N/A	70.5%	67.3%
Cervical Cancer Screening (CCS)						
Rate	18.3%	50.6%	50.6%	60.3%	54.7%	51.1%
Effectiveness of Care: Respiratory Conditions						
Medication Management for People With Asthma (MMA)						
≥ 50% treatment period (5-11 years) [1]	N/A	45.1%	45.7%	NR	49.9%	50.7%
≥ 50% treatment period (12-18 years) [1]	N/A	47.7%	48.1%	NR	50.0%	45.5%
≥ 50% treatment period (19-50 years) [1]	N/A	51.4%	57.4%	NR	62.3%	51.3%
≥ 50% treatment period (51-64 years) [1]	N/A	65.1%	69.8%	NR	75.5%	68.8%
≥ 50% treatment period (total)[1]	N/A	54.4%	55.7%	45.0%	60.0%	54.5%
≥ 75% treatment period (5-11 years)	N/A	20.2%	25.0%	NR	30.4%	27.3%
≥ 75% treatment period (12-18 years)	N/A	26.1%	25.3%	NR	31.0%	23.1%
≥ 75% treatment period (19-50 years)	N/A	31.4%	33.0%	NR	41.2%	30.7%
≥ 75% treatment period (51-64 years)	N/A	44.2%	43.1%	NR	56.1%	47.2%
≥ 75% treatment period (total)	N/A	30.5%	32.1%	19.4%	40.1%	32.6%
Effectiveness of Care: Cardiovascular Conditions						
Controlling High Blood Pressure (CBP)						
Rate	NR	36.5%	49.9%	29.0%	44.0%	51.8%
Effectiveness of Care: Diabetes						
Comprehensive Diabetes Care (CDC)						
Hemoglobin A1c (HbA1c) Testing	65.2%	61.8%	73.7%	79.7%	72.1%	64.2%
HbA1c Poor Control (>9.0%)[2]	98.5%	81.4%	68.6%	70.6%	62.6%	72.5%
HbA1c Control (<8.0%)	1.1%	15.5%	27.0%	21.0%	30.8%	20.6%
HbA1c control (<7.0%) for a Selected Population	0.8%	10.0%	17.7%	NR	21.7%	13.2%
Eye Exam	14.9%	21.9%	15.0%	25.6%	29.2%	26.8%
Medical Attention for Nephropathy	89.0%	89.8%	94.9%	93.6%	92.0%	88.3%
BP Control (<140/90 mmHG)	0.0%	35.2%	50.0%	NR	46.0%	51.1%
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (AMM)						
Acute	56.4%	45.9%	44.8%	49.7%	36.3%	43.3%
Continuation	43.3%	34.2%	31.4%	32.0%	19.3%	24.2%

HEDIS 2016 Measure/Data Element	First Medical	MMM-NE	PMC	Molina	Triple-S (Metro North)	Triple-S (West)
Follow-up Care for Children Prescribed ADHD Medication (ADD)						
Initiation	N/A	48.0%	63.5%	BR	30.2%	38.6%
Continuation	N/A	63.6%	72.7%	BR	64.4%	43.6%
Follow-up After Hospitalization for Mental Illness (FUH)						
7 day	52.4%	47.2%	41.8%	45.7%	62.9%	71.7%
30 day	68.4%	77.1%	79.2%	69.0%	81.6%	85.1%
Medication Management: Overuse/Appropriateness						
Appropriate Treatment for Children With Upper Respiratory Infection (URI)						
Rate	78.4%	81.9%	66.5%	87.7%	76.1%	80.0%
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
20-44 Years	61.5%	63.5%	64.3%	71.4%	64.6%	59.9%
45-64 Years	77.8%	80.4%	79.5%	82.8%	79.4%	77.3%
65+ Years	80.4%	81.4%	83.3%	84.5%	81.6%	80.9%
Total	69.2%	71.3%[3]	71.5%[3]	NR	71.2%[3]	68.0%[3]
Children and Adolescents' Access to Primary Care Practitioners (CAP)						
12-24 Months	83.8%	84.7%	84.7%	60.0%	89.0%	88.3%
25 Months - 6 Years	75.3%	76.9%	76.4%	77.7%	83.1%	83.2%
7-11 Years	N/A	81.2%	80.2%	BR	87.5%	87.3%
12-19 Years	N/A	73.4%	75.1%	BR	80.1%	78.6%
Annual Dental Visit (ADV)						
2-3 years	43.1%	50.5%	38.5%	NR	47.3%	40.6%
4-6 years	56.8%	66.2%	67.4%	NR	70.0%	65.7%
7-10 years	51.9%	61.5%	62.2%	NR	65.4%	66.3%
11-14 years	47.0%	53.9%	54.1%	NR	58.7%	61.5%
15-18 years	42.0%	49.8%	49.3%	NR	54.4%	56.6%
19-20 years	36.6%	45.1%	43.7%	NR	47.3%	51.2%
Total	46.8%	55.2%	53.9%	35.9%	58.5%	58.8%
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	17.7%	68.9%	40.4%	14.4%	83.7%	79.8%
Postpartum Care	13.5%	21.9%	18.3%	16.6%	30.2%	24.1%
Utilization[4]						

HEDIS 2016 Measure/Data Element	First Medical	MMM-NE	PMC	Molina	Triple-S (Metro North)	Triple-S (West)
Frequency of Prenatal Care (FPC) [4]						
< 21 % of EV	11.7%	11.2%	45.5%	NR	2.4%	2.0%
21-40% of EV	17.9%	6.1%	10.5%	NR	2.7%	2.7%
41-60 % of EV	21.6%	13.9%	9.0%	NR	7.3%	8.0%
61-80 % of EV	30.8%	20.9%	17.3%	NR	19.2%	38.4%
≥ 81% of EV	18.1%	47.9%	17.8%	5.8%	68.4%	48.9%
Well-Child Visits in the First 15 Months of Life (W15)[4]						
0 Visits	N/A	35.0%	29.7%	NR	29.7%	45.3%
1 Visit	N/A	22.9%	20.0%	NR	18.3%	23.1%
2 Visits	N/A	11.4%	17.0%	NR	14.8%	12.9%
3 Visits	N/A	12.4%	12.7%	NR	12.7%	7.5%
4 Visits	N/A	5.6%	8.0%	NR	7.8%	4.1%
5 Visits	N/A	3.7%	6.6%	NR	7.1%	3.2%
6+ Visits	N/A	9.0%	6.1%	BR	9.7%	3.9%
Adolescent Well-Care Visits (AWC)[4]						
Rate	14.0%	25.1%	28.2%	19.7%	29.7%	14.6%
Frequency of Selected Procedures (FSP)[4]						
Bariatric weight loss surgery (0-19 years; male) per 1000 member months	NR	0.0	0.0	0.0	0.0	0.0
Bariatric weight loss surgery (0-19 years; female) per 1000 member months	NR	0.0	0.0	0.0	0.0	0.0
Bariatric weight loss surgery (20-44 years; male) per 1000 member months	NR	0.0	0.0	0.0	0.0	0.0
Bariatric weight loss surgery (20-44 years; female) per 1000 member months	NR	0.0	0.0	0.0	0.0	0.0
Bariatric weight loss surgery (45-64 years; male) per 1000 member months	NR	0.0	0.0	0.0	0.0	0.0
Bariatric weight loss surgery (45-64 years; female) per 1000 member months	NR	0.0	0.0	0.0	0.0	0.0
Tonsillectomy (0-9 years) per 1000 member months	NR	0.1	0.1	0.1	0.1	0.1
Tonsillectomy (10-19 years) per 1000 member months	NR	0.0	0.0	0.0	0.0	0.0

HEDIS 2016 Measure/Data Element	First Medical	MMM-NE	PMC	Molina	Triple-S (Metro North)	Triple-S (West)
Hysterectomy, abdominal (15-44 years) per 1000 member months	NR	0.3	0.4	0.4	0.4	0.3
Hysterectomy, abdominal (45-64 years) per 1000 member months	NR	0.5	0.7	0.7	0.5	0.6
Hysterectomy, vaginal (15-44 years) per 1000 member months	NR	0.1	0.1	0.0	0.0	0.0
Hysterectomy, vaginal (45-64 years) per 1000 member months	NR	0.1	0.1	0.1	0.1	0.1
Cholecystectomy, open (30-64 years; male) per 1000 member months	NR	0.0	0.0	0.0	0.0	0.0
Cholecystectomy, open (15-44 years; female) per 1000 member months	NR	0.0	0.0	0.0	0.0	0.0
Cholecystectomy, open (45-64 years; female) per 1000 member months	NR	0.0	0.0	0.1	0.1	0.0
Cholecystectomy, laparoscopic (30-64 years; male) per 1000 member months	NR	0.3	0.3	0.3	0.3	0.4
Cholecystectomy, laparoscopic (15-44 years; female) per 1000 member months	NR	0.6	0.7	0.6	0.6	0.7
Cholecystectomy, laparoscopic (45-64 years; female) per 1000 member months	NR	0.7	0.7	0.7	0.8	0.9
Back Surgery (20-44; male) per 1000 member months	NR	0.0	0.0	0.0	0.0	0.1
Back Surgery (20-44; female) per 1000 member months	NR	0.0	0.0	0.1	0.0	0.1
Back Surgery (45-64; male) per 1000 member months	NR	0.1	0.1	0.1	0.1	0.1
Back Surgery (45-64; female) per 1000 member months	NR	0.0	0.1	0.1	0.1	0.1
Mastectomy (15-44; female) per 1000 member months	NR	0.0	0.0	0.0	0.0	0.0
Mastectomy (45-64; female) per 1000 member months	NR	0.1	0.1	0.1	0.1	0.1

HEDIS 2016 Measure/Data Element	First Medical	MMM-NE	PMC	Molina	Triple-S (Metro North)	Triple-S (West)
Lumpectomy (15-44; female) per 1000 member months	NR	0.2	0.1	0.1	0.1	0.2
Lumpectomy (45-64; female) per 1000 member months	NR	0.5	0.4	0.4	0.3	0.3
Ambulatory Care (AMB)[4]	**Procedures per 1000 member months**					
Outpatient visits per 1000 member months	NR	265.6	262.0	245.3	275.8	274.7
ED visits per 1000 member months	NR	67.2	92.9	99.8	75.0	99.8
Identification of Alcohol and Other Drug Services (IAD)[4]						
Any chemical dependency service	NR	1.6	1.5	1.5%	1.3%	1.3%
Inpatient chemical dependency service	NR	0.3	0.3	0.2%	0.0%	9.0%
Intensive outpatient or partial hospitalization chemical dependency service	NR	0.0	0.0	0.0%	0.0%	0.0%
Outpatient or ED chemical dependency service	NR	1.5	1.4	1.4%	1.3%	1.3%
Mental Health Utilization (MPT)[4]						
Any mental health service	NR	10.5	12.0	9.8%	17.1%	13.0%
Inpatient mental health service	NR	0.3	0.5	0.3%	0.4%	0.3%
Intensive outpatient or partial hospitalization mental health service	NR	0.1	0.1	0.3%	0.2%	3.0%
Outpatient or ED mental health service	NR	10.5	12.0	9.7%	17.0%	12.9%

[1] NCQA average not available for this measure.
[2] A lower rate indicates better performance.
[3] MMM/PMC and Triple-S total rates calculated by IPRO. MCOs did not report total rates but did report numerators and denominators allowing calculation of a total rate.
[4] Rates for utilization measures are not compared to NCQA average. From the HEDIS specifications: "NCQA does not view higher or lower service counts as indicating better or worse performance."

Medicare Advantage (Platino) HEDIS 2017

The following table reports HEDIS 2017 measures for Medicare Advantage (Platino) plans. When available a single rate is reported for each plan. If plans only supplied HEDIS 2017 data by region/product, HEDIS rates are reported by region/product.

Rates highlighted in green are at or above[8] the Medicare NCQA national average[9]. Reasons for missing rates are indicated using the following:

- NR = not reported by plan. If the plan did not specify a reason for not reporting a measure they received an NR.
- NQ = not required (as reported by MCO)
- N/A = not reported because of a small denominator (n < 30).
- BR = biased rate

Table 31: HEDIS 2017 Medicare Advantage (Platino)

HEDIS 2017 Measure/Data Element	Constell-ation 11761	Constell-ation 11762	Constell-ation 13219	Humana	MCS - 8882	MCS - 13181	MCS - 13182	MMM - 9228	MMM - 13246	MMM - 12442	Triple-S 9271	Triple-S 13348
Effectiveness of Care: Prevention and Screening												
Adult BMI Assessment (ABA)												
Rate	94.4%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	98.1%	NR
Breast Cancer Screening (BCS)												
Rate	69.8%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	82.9%	NR
Colorectal Cancer Screening (COL)												
Rate	67.6%	68.1%	N/A	84.9%	81.5%	86.8%	80.4%	92.4%	94.8%	87.8%	82.7%	90.8%
Care for Older Adults (COA)[1]												
Advance Care Planning	NQ	70.1%	82.5%	69.8%	87.6%	90.4%	89.6%	98.0%	98.0%	93.4%	NR	53.3%
Medication Review	NQ	89.8%	91.7%	94.9%	96.8%	99.1%	93.2%	98.0%	98.0%	95.3%	NR	93.4%
Functional Status Assessment	NQ	91.7%	92.5%	90.8%	97.2%	98.6%	95.2%	98.0%	98.0%	94.3%	NR	97.1%
Pain Assessment	NQ	91.0%	92.2%	93.4%	98.0%	98.6%	96.0%	98.0%	98.0%	94.3%	NR	96.4%
Effectiveness of Care: Respiratory Conditions												
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)												
Rate	N/A	N/A	50.0%	26.5%	0.8%	1.4%	N/A	30.5%	22.5%	N/A	32.1%	28.3%
Pharmacotherapy Management of COPD Exacerbation (PCE)												
Systemic Corticosteroid	34.2%	30.7%	38.4%	37.5%	35.5%	42.0%	N/A	40.3%	34.4%	N/A	47.2%	49.1%
Bronchodilator	57.6%	58.5%	56.4%	65.4%	54.3%	52.2%	N/A	53.6%	47.4%	N/A	65.9%	69.4%
Medication Management for People With Asthma (MMA)[1]												
18-50 Years: Medication Compliance 50%	N/A	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	63.6%	NR
18-50 Years: Medication Compliance 75%	N/A	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	42.4%	NR

[8] If a low rate is desirable it is noted in the table. For these measures, rates are highlighted if they are at or below the NCQA national average.
[9] Comparison is made with NCQA national average category 'All LOBs Excluding PPOs and EPO' [892].

HEDIS 2017 Measure/Data Element	Constell-ation 11761	Constell-ation 11762	Constell-ation 13219	Humana	MCS - 8882	MCS - 13181	MCS - 13182	MMM - 9228	MMM - 13246	MMM - 12442	Triple-S 9271	Triple-S 13348
51-64 Years: Medication Compliance 50%	N/A	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	83.5%	NR
51-64 Years: Medication Compliance 75%	N/A	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	56.5%	NR
65-85 Years: Medication Compliance 50%	N/A	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	81.9%	NR
65-85 Years: Medication Compliance 75%	N/A	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	60.9%	NR
Total: Medication Compliance 50%	91.7%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	80.6%	NR
Total: Medication Compliance 75%	55.6%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	58.2%	NR
Asthma Medication Ratio (AMR) [1]												
18-50 Years	N/A	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	81.1%	NR
51-64 Years	N/A	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	80.6%	NR
65-85 Years	N/A	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	89.2%	NR
Total	85.4%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	86.3%	NR
Effectiveness of Care: Cardiovascular Conditions												
Controlling High Blood Pressure (CBP)												
Rate	BR	BR	BR	63.3%	71.0%	81.3%	82.5%	72.2%	76.0%	77.1%	59.6%	50.1%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)												
Rate	81.0%	N/A	N/A	85.2%	91.5%	88.0%	N/A	86.2%	83.1%	N/A	88.4%	92.3%
Statin Therapy for Patients with Cardiovascular Disease (SPC)												
Received Statin Therapy: 21-75 Years (Male)	91.6%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	74.7%	NR
Statin Adherence 80%: 21-75 Years (Male)	67.4%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	72.3%	NR
Received Statin Therapy: 40-75 Years (Female)	83.3%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	73.9%	NR
Statin Adherence 80%: 40-75 Years (Female)	49.3%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	66.1%	NR
Received Statin Therapy: Total	87.8%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	74.3%	NR
Statin Adherence 80%: Total	59.5%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	69.5%	NR

HEDIS 2017 Measure/Data Element	Constell-ation 11761	Constell-ation 11762	Constell-ation 13219	Humana	MCS - 8882	MCS - 13181	MCS - 13182	MMM - 9228	MMM - 13246	MMM - 12442	Triple-S 9271	Triple-S 13348
Effectiveness of Care: Diabetes												
Comprehensive Diabetes Care (CDC)												
Hemoglobin A1c (HbA1c) Testing	93.9%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	94.4%	NR
HbA1c Poor Control (>9.0%)[2]	52.3%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	26.0%	NR
HbA1c Control (<8.0%)	33.1%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	56.5%	NR
Eye Exam	65.7%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	81.5%	NR
Medical Attention for Nephropathy	99.0%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	98.8%	NR
BP Control (<140/90 mmHG)	81.5%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	71.8%	NR
Statin Therapy for Patients With Diabetes (SPD)												
Received Statin Therapy	74.8%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	66.8%	NR
Statin Adherence 80%	60.4%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	66.9%	NR
Effectiveness of Care: Musculoskeletal												
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)												
Rate	72.9%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	71.9%	NR
Osteoporosis Management in Women Who Had a Fracture (OMW)												
Rate	N/A	N/A	N/A	32.9%	52.5%	69.7%	N/A	86.2%	86.4%	N/A	30.9%	31.0%
Effectiveness of Care: Behavioral Health												
Antidepressant Medication Management (AMM)												
Acute	55.2%	53.3%	68.6%	54.9%	59.4%	61.2%	67.5%	57.7%	62.8%	63.6%	54.9%	61.5%
Continuation	39.3%	36.1%	62.9%	36.6%	52.6%	45.0%	45.0%	42.1%	42.1%	41.6%	41.1%	47.3%
Follow-up After Hospitalization for Mental Illness (FUH)												
7 day	52.4%	50.0%	55.4%	0.0%	54.8%	52.6%	N/A	47.4%	41.4%	N/A	51.4%	54.6%
30 day	75.9%	72.5%	80.0%	0.0%	79.8%	81.4%	N/A	70.4%	58.6%	N/A	80.6%	84.7%
Follow-Up After Emergency Department Visit for Mental Illness (FUM) [1]												
7 day	43.3%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	25.8%	NR
30 day	60.0%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	51.6%	NR
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) [1]												
30-Day Follow-Up: 13-17 Years	N/A	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	NR	NR
7-Day Follow-Up: 13-17 Years	N/A	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	NR	NR
30-Day Follow-Up: 18+ Years	16.7%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	3.9%	NR

HEDIS 2017 Measure/Data Element	Constell-ation 11761	Constell-ation 11762	Constell-ation 13219	Humana	MCS - 8882	MCS - 13181	MCS - 13182	MMM - 9228	MMM - 13246	MMM - 12442	Triple-S 9271	Triple-S 13348
7-Day Follow-Up: 18+ Years	16.7%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	3.9%	NR
30-Day Follow-Up: Total	16.7%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	3.9%	NR
7-Day Follow-Up: Total	16.7%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	3.9%	NR
Effectiveness of Care: Medication												
Annual Monitoring for Patients on Persistent Medications (MPM)												
ACE Inhibitors or ARBs	95.4%	94.4%	96.6%	96.1%	94.9%	96.2%	96.2%	95.5%	74.6%	96.4%	94.6%	94.5%
Digoxin	32.0%	24.7%	42.9%	44.3%	38.1%	34.4%	N/A	30.6%	30.8%	N/A	39.7%	36.6%
Diuretics	95.3%	95.0%	95.7%	96.5%	95.5%	96.6%	94.8%	95.9%	94.9%	96.9%	94.8%	94.6%
Total	94.3%	93.3%	95.5%	95.7%	94.3%	95.7%	95.2%	94.7%	93.2%	95.6%	93.9%	93.6%
Medication Reconciliation Post-Discharge (MRP)												
Rate	11.4%	13.1%	19.0%	14.2%	31.9%	38.2%	31.4%	40.9%	41.1%	41.7%	27.0%	23.6%
Medication Management: Overuse/Appropriateness												
Non-Recommended PSA-Based Screening in Older Men (PSA)[2]												
Rate	68.2%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	63.1%	NR
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [2]												
Falls + Anticonvulsants, Nonbenzodiazepine hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines or Tricyclic Antidepressants	60.5%	57.9%	N/A	61.1%	58.5%	66.4%	N/A	60.8%	56.2%	N/A	56.0%	61.3%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine hypnotics or Anticholinergic Agents	77.7%	77.6%	N/A	76.5%	73.0%	79.1%	N/A	71.1%	72.1%	N/A	68.2%	75.0%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-aspirin NSAIDs	43.5%	42.9%	N/A	34.5%	28.4%	37.3%	N/A	34.6%	31.0%	N/A	28.4%	30.6%
Total	67.4%	67.1%	N/A	63.6%	60.7%	67.3%	60.3%	60.1%	59.9%	65.1%	58.7%	63.0%
Use of High-Risk Medications in the Elderly (DAE) [2]												
One prescription	31.9%	28.3%	36.5%	27.0%	26.9%	36.3%	29.2%	22.5%	21.0%	17.2%	18.7%	24.4%
At least two prescriptions	14.4%	12.9%	15.8%	14.5%	12.4%	16.7%	12.0%	11.3%	11.3%	8.2%	9.1%	12.6%
Access/Availability of Care												
Adults' Access to Preventive/Ambulatory Health Services (AAP)												
20-44 Years	98.0%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	97.9%	NR

HEDIS 2017 Measure/Data Element	Constell-ation 11761	Constell-ation 11762	Constell-ation 13219	Humana	MCS - 8882	MCS - 13181	MCS - 13182	MMM - 9228	MMM - 13246	MMM - 12442	Triple-S 9271	Triple-S 13348
45-64 Years	99.3%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	98.7%	NR
65+ Years	99.1%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	97.8%	NR
Total	99.1%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	98.0%	NR
Initiation and Engagement of AOD Dependence Treatment (IET)												
Initiation of AOD[1] Treatment: 13-17 Years	N/A	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	NR	NR
Engagement of AOD[1] Treatment: 13-17 Years	N/A	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	NR	NR
Initiation of AOD Treatment: 18+ Years	18.9%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	15.5%	NR
Engagement of AOD[1] Treatment: 18+ Years	0.8%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	1.9%	NR
Initiation of AOD[1] Treatment: Total	18.9%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	15.5%	NR
Engagement of AOD Treatment: Total	0.8%	NQ	NQ	NR	NQ	NQ	NQ	NQ	NQ	NQ	1.9%	NR

[1] NCQA average not available for this measure.
[2] A lower rate indicates better performance.
[3] Constellation Health.

V. Performance Improvement Projects

Medicaid PIPs

This section of the report presents the results of IPRO's evaluation of the Medicaid performance improvement projects (PIPs) submitted by First Medical, MMM, Molina, and Triple-S for the contract period 2016–2017. The assessment was conducted using a methodology developed by IPRO and consistent with CMS EQR protocols for PIP Validation.

Table 32: Summary of Medicaid PIP Projects

Plan	PIP	PIP Measurement Years
First Medical	Behavioral Readmissions	2016 - 2017
	Co-location and Reverse Co-location	2016 - 2017
	EPSDT	2016 - 2017
	Increase use of Fistula	2016 - 2017
MMM	Improve follow-up care visits for children with ADHD	2015 - 2016
	Increase ASQ-3 Use and Reporting	2016 - 2017
	Increase use of renal AVF	2015 - 2017
	Use & Reporting of Mental Health Services at PMGs	2016 - 2017
Molina	Arteriovenous Fistula (AVF) usage improvement Initiative	2016 - 2018
	Improvement in Behavioral Health Inpatient to Outpatient Transitions of Care	2016 - 2018
	Improving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Screening Rates	2016 - 2018
	Primary Care Physician and Behavioral Health Collaborative Care Project	2016 - 2018
Triple-S	Establish and comply with the Reverse Co-location Model in compliance with Reverse Collocation Guidelines as established by ASES	2016 - 2018
	Improve the Adherence of Antidepressant Medication Management (AMM)	2014 - 2018
	Improve the Communication Between Behavioral Health Providers and PCPs I Co-location Model	2016
	Renal Condition PIP: Health care services for PSG patients with Renal Conditions under Special Coverage receiving services with PR Renal Clinic and fistula as treatment option	2016 - 2017
	Well Child Visits	2016 - 2018

First Medical Performance Improvement Projects

1. Behavioral Readmissions

PIP Topic: Reducing hospital readmission rate

Study Question/Objectives

The plan states the following objective: to reduce the readmission rate within 30 days of discharge for Plan de Salud del Gobierno (PSG) patients with a mental health condition.

Goals for 2016 and 2017: Any decrease in the percentage of the readmission rate compared with the previous year result.

Measurement Period

Baseline years indicated: 2015
Subsequent year(s) indicated: 2016, 2017

Population: PSG patients who have a principal mental health diagnosis and who were discharged from an acute inpatient setting (including acute care psychiatric facilities).

Methodology/ Performance Indicators: All PSG members with any mental health diagnosis with a readmission or a direct transfer to an acute facility within 30-days. If multiple discharges occur within 30 days of each other, we will use the last discharge. If multiple discharges occur more than
30 days apart, we will use all discharges dates. Inpatient claims and encounter data processed in APS-PR NEO system will be used to calculate the selected measures

Interventions: The plan indicated the following interventions:

- An individualized care plan
- Screening tools
- Educational material
- Monitoring of the enrollee needs, assistance and additional services via telephonic contact at least every three (3) months
- Follow-up includes but is not limited to counseling, referrals, enrollee's education, self-management support.
- Referrals to other health organizations and/or community resources when appropriate They remain in contact with the enrollee to verify if referrals were completed.
- Referrals to a behavioral health specialist, subspecialist or any other provider, as establish in their individualized care plan. They will contact such a professional directly to assist enrollees without a referral process. This will ensure a seamless appointment coordination to address behavioral health needs rapidly and efficiently.
- Identified physical needs will be addressed directly with the MCO's care manager via direct discussion and document sharing.

Results: The plan presented data for each region showing monthly readmission rates by region.

Discussion: The plan indicates their 2016 and 2017 goals of any improvement of the readmission rate over the prior year were met.

Improvement shown? The plan indicates that there was improvement in the readmission rate each year. Without an overall readmission rate reported for the entire year and across regions, it is difficult to evaluate this claim.

Strengths: Interventions targeting members, providers, and MCO.

Opportunities for Improvement

- Insufficient information about the details of the interventions provided
- It is recommended that intervention tracking measures be included in future PIPs to help identify the success of interventions.
- For future PIPs, it is recommended that the plan develop and monitor monthly Intervention Tracking Measures (ITMs) for each intervention; identify stagnating or declining ITM monthly trends; conduct root cause/barrier analysis; and use findings to inform modifications to interventions on an ongoing basis throughout the course of the PIP. Monthly ITM trends could be monitored using run charts. Plan-Do-Study-Act (PDSA) worksheets could be used to plan, monitor and interpret progress of key interventions that represent meaningful tests of change and, with improved ITM rates, used to spread successes to impact a greater proportion of members.

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to lack of clear specification of performance indicator and interventions.

2. Co-location and Reverse Co-location

PIP Topic: Co-location and Reverse Co-location compliance

Study Question/Objectives: The plan states that the Collocation Model uses specialty mental health clinicians who provide services at the same site as primary care, as per guidelines and the required Integrated Model. Some are the benefits of the Integration of Physical and Behavioral Health Services Model: increase health outcomes, improve quality of life and decrease fragmentation of care integrating the system through coordination of as much as possible aspects of a patient's life.

The plan states that the Reverse co-location model considers having a Primary Care Provider (physician, or nurse) may be out-stationed part- or full-time, in a psychiatric specialty setting to monitor the physical health of patients. This approach seeks to improve health care for persons with severe and persistent mental illness.

The plan states that the objective of the colocation PIP is to: comply with an adequate provider ratio to attain collocation in primary care settings.

The plan states that the objective of the colocation PIP is to: demonstrate adequate provider ratio to attain reverse collocation in any specialty clinics and facilities, including ASSMCA Community Centers and any other facility serving patients with mental health conditions. All BHF must comply with the ASES reverse co-location guidelines in 100%.

Measurement Period
Baseline years indicated: April 2014 – March 2015
Subsequent year(s) indicated: April – September 2016; April 2015 – December 2017.

Population: All patients receiving co-location services at the PMG
All members receiving reverse co-location services at Behavioral Health Facilities (BHF)

Methodology/ Performance Indicators: Compliance was monitored by quarterly facility audits.

Interventions
In 2016 in response to: Tracking codes implementation in the EMR for case discussion between BHP and PCP accounting.
The plan implemented the following intervention: EMR implementation set for April 2017. Improvement expected to be reported on July-September 2017 Quarter.

Results: The plan reported monthly percentages of cases discussed between the BHP and PCP by region for 2016 and 2017. The percentage of facilities in compliance with the reverse colocation guidelines was also reported monthly by region for 2016 and 2017.

Discussion: The plan states for reverse colocation: as the expected result was achieved a decision to do a quarterly count of reverse co-location services was established.

Improvement shown? The plan states that they achieved their goal for both colocation and reverse colocation.

Strengths: This appears to be a compliance report, and compliance does appear to have been attained per the plan's stated results; however, findings do not represent those of an independent EQRO compliance review.

Opportunities for Improvement: Implement a PIP to improve member access to services to integrate behavioral health with physical health.

Overall Credibility of Results: There are one or more validation findings that indicate a bias in the PIP results. This was a compliance monitoring project rather than a Performance Improvement Project.

3. EPSDT

PIP Topic: EPSDT improvement

Study Question/Objectives: Plans stated goals are: promote enrollees/parents awareness and responsibility, encourage provider responsibility, ensure access to primary and preventive care services, improve access to all necessary healthcare services, increase enrollee safety, client autonomy, and adherence to treatment plans, encourage quality, continuity, and appropriateness of medical care, promote healthy behaviors, provide medical coverage in a cost-effective manner and actively and diligently participate in the efforts by PRHIA and the Puerto Rico Department of Health for the prevention, promotion and education in health and EPSDT Program.

Reported objectives for 2016 and 2017 objectives: Efforts during 2016 and 2017 were directed to develop the intelligence for EPSDT reports in order to identify the population that needs every service by age. Additional efforts were performed to identify the codes for each specific service included in the Program and clarify the PRHIA Benefits' Policy for this Program.

Measurement Period

Baseline years indicated: N/A
Subsequent year(s) indicated: 2016, 2017

Population: Children under 21

Methodology/ Performance Indicators
Interventions: Specific trainings were provided to Health Care Providers and beneficiaries/parents/authorized representatives during 2016 and 2017.

FMHP sent EPSDT mailings to all Contracted Providers in order to educate them of the Program and the related preventive services to be offered to the Medicaid Children Population on May 20, 2016 and September 8, 2016 and on June 20, 2017.

Results: N/A

Discussion: N/A

Improvement shown? N/A

Strengths: As per the plans state objective, the purpose of this project appears to be information gathering.

Opportunities for Improvement: Implement a PIP to improve EPSDT screening and treatment.

- For future PIPs, it is recommended that the plan develop and monitor monthly Intervention Tracking Measures (ITMs) for each intervention; identify stagnating or declining ITM monthly trends; conduct root cause/barrier analysis; and use findings to inform modifications to interventions on an ongoing basis throughout the course of the PIP. Monthly ITM trends could be monitored using run charts. Plan-Do-Study-Act (PDSA) worksheets could be used to plan, monitor and interpret progress of key interventions that represent meaningful tests of change and, with improved ITM rates, used to spread successes to impact a greater proportion of members.

Overall Credibility of Results: There are one or more validation findings that indicate a bias in the PIP results. This appears to be an information gathering project rather than a Performance Improvement Project.

4. Increase use of Fistula

PIP Topic: Improvement of arterial venous fistula (AVF) utilization.

Study Question/Objectives

- To develop strategies to improve arterial venous fistula (AVF) utilization in Government Health Plan population

- To explore the challenges and successes for fistula placement within the dialysis and surgical communities by Region.
- Improve the coordination of care across providers and disseminate best practices based on clinical practice guidelines.
- Align contractual strategies to promote improvement of AVF utilization rates.
- Educate members on early stages of ESRD about the AVF.
- Link all care management programs to promote AVF education in members in high risk for dialysis: wellness, disease management, complex case management, utilization management, Transitional Care Management Program, etc.
- Provide training to health professionals managing this population.

Measurement Period:

Baseline years indicated: No baseline
Subsequent year(s) indicated: 2016, 2017

Population: Members with stage 3,4, and 5 chronic renal disease.
2016: 322, 2017: 284.

Methodology/ Performance Indicators: Performance indicator: The percentage of beneficiaries with stage 3, 4, and 5 Chronic Kidney Disease who have an AV Fistula Placement in the next 6 to 18 months. Claims data is used.

Interventions

- Proper identification of enrollees with high risk for dialysis,
- Education strategies with identified target patients,
- Outbound phone calls for patient coaching,
- Mailing education materials to targeted enrollees
- Providers encourage the evaluations of the AV fistula as per guidelines and,
- Yearly Monitoring Project Activity and Outcomes based on achievement thresholds.

Results : *Performance indicators*

Percentage of beneficiaries with an AV Fistula:

Baseline: Not reported

2016: 20.81% of eligible population received a fistula.

2017: 17.61% of eligible population received a fistula.

Intervention tracking measures

2016: 99% of members received the positive interventions (written educational material and telephonic coaching).

2017: 99.6% of members received the positive interventions (written educational material and telephonic coaching).

Discussion

- FMHP has a considerable percentage of non-contact enrollees in 2016 (over 30%). This situation increased during the last quarter of 2017 due the atmospheric event.
- The long wait times for surgical review and access placement, could be related to misunderstanding by beneficiaries about the impact and risk of not having a timely AV Fistula Placement.
- FMHP are looking alternate strategies to increase the percentage of contact information and to promote the insertion of an arterial venous fistula before the dialysis process.

- The promotion to physician of the CKD Guidelines for the best practice is other strategy to improve percentage of enrollees having timely AV Fistula.

Improvement shown? Improvement in 2016 cannot be determined without a baseline rate. There was no improvement from 2016 to 2017.

Strengths

- Active member interventions
- Topic rationale demonstrates relevance to the MCO's member population through MCO-specific data

Opportunities for Improvement

- A more rigorous approach to performance indicator specification, measurement and reporting is indicated.
    - A baseline rate needs to be established to identify if the interventions were successful in improving the performance measure.
    - Performance measure indicates a measurement period of 6 to 18 months after intervention. Results do not reflect this period.
- It is recommended that the plan use tracking measures for each intervention to help identify the whether the intervention was successfully implemented.
- For future PIPs, it is recommended that the plan conducts root cause/barrier analysis
- More detailed information on interventions could be provided

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to lack of performance measure baseline rate, and information about interventions.

MMM Performance Improvement Projects

1. Improve follow-up care visits for children with ADHD

PIP Topic: ADHD

Study Question/Objectives: The aim of the project is to increase the follow-up care visits with providers among the children of 6-12 years old with first or new prescription of ADHD medications in order to receive proper management for their condition. The objective of the PIP is to answer the following question: Do the educational interventions for providers implemented by MMM Multi Health for the ADHD project help to improve the follow-up care visits in children with ADHD at the Southeast and Northeast Region in at least 3% by June 30, 2017?

Measurement Period

- Baseline: January 1, 2014 to December 31, 2014
- 1st measurement: January 1, 2015 to December 31, 2015
- 2nd measurement: January 1, 2016 to December 31, 2016

Population: MMM Multi Health currently has in place a Clinical Program specifically directed to members with ADHD. The study population for the Northeast region is a total of 107 providers in charge of care for 1,312 members within 6-12 years old with ADHD diagnosis. The study population for the Southeast region is a total of 127 providers in charge of care for 1,094 members within 6-12 years old with ADHD diagnosis.

Methodology/ Performance Indicators: The indicator selected to determine the effectiveness of this project is the HEDIS measure is *Follow-up care for children prescribed ADHD Medication (ADD).* The selected study indicator will be collected annually following NCQA requirements for HEDIS with the help of our HEDIS vendor and reported to PR's EQRO (IPRO) for audit purpose.

Interventions
Provider interventions:

- Educational Campaign for providers in charge of children aged 6-12 years with first or new prescription of ADHD medications. The main focus of this educational intervention is to confirm that they have been properly following-up their patients at the ambulatory level by providing office visits within the required timeframe considering the dispensing date for an ADHD prescription to improve our rates for initiation and continuation/management phases.

Results: The results show that the expected improvement established for the project was met during 1st measurement year. The plan set a new goal of an increase of 10% by June 30th, 2017 for both, SE and NE region.

Discussion: The plan did interpret the results, and referenced the changes in percentages from earlier quarters in order to interpret improvement. Merely some bullet points for barriers to the intervention and mitigation plan were provided.

Improvement shown? The PIP states that the goal of 3% increase was met during the 1st measurement period thus a new goal was set to an increase of 10% by June 30th, 2017 for both regions. This new goal was not met for either region.

Strengths: The PIP reports improvement in patient outcomes and adjusted the goal accordingly once that was met.

Opportunities for Improvement
Key opportunities for improvement include:

- The PIP should include a thorough barrier analysis linked to related interventions.
- Interventions should be identified as new or previously established.
- Intervention tracking measures should be developed to track the effectiveness of the interventions. For example: number of providers properly following-up their patients at the ambulatory level, number of providers providing office visits within the required timeframe, number of providers involved in the education campaign who were provided the PowerPoint presentation.
- Details should be provided on numerator and denominator of the intervention tracking measure.
- In order to have a more robust PIP, it should include actions that target not only the providers but also the members, and the MCO.
- Analysis should include interpretation and discussion.

Overall Credibility of Results: The validation findings generally indicate the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to lack of statements regarding improvement in measurement year 1 or stagnation in measurement year 2 in the indicators, and the suspected impact of interventions and next steps.

2. Increase ASQ-3 Use and Reporting

PIP Topic: EPSDT Program- Administrative project

Study Question/Objectives: The main purpose of the project is to increase the use and the proper reporting of the ASQ-3 by providers among the children of 9-30 months old in order to receive proper screenings, diagnostics and treatments for their health needs as part of the benefits included in the EPSDT Program. The plan defined the study question as follows: Do the educational interventions for providers implement by MMM Multi Health for the EPSDT project will help to improve the use and the reporting of the ASQ-3 in children of 9-30 months old at the Northeast and Southeast Region in at least 3% by June 30, 2017?

Measurement Period

- Baseline: April 15, 2015 to December 31, 2015
- 1st measurement: January 1, 2016 to September 30, 2016
- 2nd measurement: October 1, 2016 to June 30, 2017

Population: MMM Multi Health currently has in place an EPSDT Program as a preventive program specifically directed for Medicaid members less than 21 years old, including children. The study population for the Southeast region was a total of 152 providers in charge of the care for 6,038 members within 9-30 months old. The study population for the Northeast region was a total of 125 providers in charge of the care for 5,803 members within 9-30 months old.

Methodology/ Performance Indicators: The indicator selected to determine the effectiveness of this project was an internal indicator that measured the percent of ASQ-3 done among the members of 9 to 30 months old enrolled in MMM Multi Health during the study period. The data source for this indicator was an administrative data included in claims submitted by providers through the Claim system. Any claim submitted by the providers on the study population with CPT codes -96110 or 96111- for members of 9, 18, 24, and 30 months old during the project period was consider a positive hit.

Interventions

Provider interventions:

The main strategy of this project is an Educational Campaign for the providers in charge of children with 9, 18, 24, and 30 months old with no evidence of ASQ-3 performed during the study period. The main focus of this educational intervention is to confirm that they are been properly following-up their patients at the ambulatory level by performing screening, diagnostic and treatment services, including ASQ-3, within the required timeframe considering the EPSDT Program schedule to improve our rates.

Results

The following table illustrates the final ASQ-3 rate reported for the 2nd measurement period for the Northeast Region.

Study indicator	Baseline result	1st measurement result	2nd measurement result	Expected Improvement (↑3%)
ASQ-3 rate	0.0%	1.31% (71/5,410)	4.0% (180/4,951)	MET

The following table illustrates the final ASQ-3 rate reported for the 2nd measurement period for the Southeast Region.

Study indicator	Baseline result	1st measurement result	2nd measurement result	Expected Improvement (↑3%)
ASQ-3 rate	0.10% (5/6,038)	2.31% (131/5,682)	3.40% (177/5,217)	MET

Discussion: The plan did not interpret the results, and did not provide any benchmarks, so did not interpret improvement relative to that.

Improvement shown?: Comparing Q1 2016 to Q3 2016, the increase from 0.8% to 2.4% in Southeast region and Q4 2016 to Q2 2017, the increase from 2.2% to 5.0% in Northeast region of the 'ASQ rates observed by the surveillance done quarterly' does appear to have shown improvement.

Strengths: The MCO demonstrated improvement for the indicator for both regions.

Opportunities for Improvement

Key opportunities for improvement include:

- The MCO should provide detail on the eligible population, specifically whether the denominator is limited to those providers who do not use and report the ASQ-3 in children of 9-30 months old. Numerators and denominators should be displayed in results tables for percentages.

- Use of HEDIS specifications as performance indicator would be ideal to measure increase or decrease of performance.
- Study indicators should specify comparison to external benchmarks.
- The MCO should develop further interventions. Relying on one intervention to improve rates is not ideal.
- All data tables should be accompanied by narrative explanation and interpretation.
- Analysis should contain an interpretation of the results.
- In order to have a more robust PIP, it should include actions that target not only the providers but also the members, and the MCO.

Overall Credibility of Results: The validation findings generally indicate the credibility of the PIP results is not at risk. Results should be interpreted with some caution due to the following: the PIP contained no statements regarding improvement in measurement year 1 and measurement year 2 in the indicators, nor the suspected impact of interventions and next steps.

3. Increase Use of Renal AVF

PIP Topic: Use of Arteriovenous Fistula

Study Question/Objectives: The main purpose of the project is to increase the use of the renal AVF among the members diagnosed with CKD stage 4. The objective of the PIP is to answer the following question: Do the educational interventions for providers implement by MMM Multi Health for the AVF project help to increase the use of renal AVF among patients diagnosed with CKD stage 4 at the Northeast and Southeast Region in at least 3% by June 30, 2017?

Measurement Period

- Baseline: 2015
- 1st measurement: January 1, 2015 to September 30, 2016.
- 2nd measurement: October 1, 2016 to June 30, 2017

Population: MMM Multi Health currently has a Clinical Program in place specifically directed to members with ESRD and CKD stages 3-5. For the Northeast region, the study population is a total of 41 PCPs and 8 Nephrologist who are in charge of care for 81 CKD stage 4 members receiving hemodialysis without AVF. For the Southeast region, the study population is a total of 62 PCPs and 3 Nephrologist who are in charge of care for 115 CKD stage 4 members receiving hemodialysis without AVF.

Methodology/ Performance Indicators: The indicator selected to determine the effectiveness of this project is an internal rate that will determine the percent of members with renal AVF among all members with CKD stage 4 for MMM Multi Health at Southeast and Northeast Region calculated as follows:

- Numerator: members diagnosed with CKD stage 4 in the denominator with a renal AVF
- Denominator: total of members diagnosed with CKD stage 4

To accomplish this, the Project Leader with the help of Claim's staff collected and analyzed medical claims on a quarterly basis during the study period to determine the percent of members with diagnosis of CKD stage 4 and a new acquisition of a renal AVF. This was cross matched with the list of providers on the study population to count it as a positive hit.

Interventions

Provider interventions: The main strategy of this project is an Educational Campaign for the providers (PCPs and Nephrologists) in charge of the members with CKD stage 4 and no renal AVF for hemodialysis. The main focus of this educational intervention is to promote the use of the AVF among this population over any other type of access considering the benefits of low complications and infections.

Results: The following table illustrates the percentage of use of renal AVF observed by the surveillance done by the Project Leader during the 1st and 2nd measurement period for Northeast Region.

Baseline result	1st measurement result	2nd measurement result	Expected Improvement (↑3%)
1.2% (1/82)	0.8% (1/132)	0.9% (2/211)	NOT MET

The following table illustrates the percentage of use of renal AVF observed by the surveillance done by the Project Leader during the 1st and 2nd measurement period for Southeast Region.

Baseline result	1st measurement result	2nd measurement result	Expected Improvement (↑3%)
0.86% (1/116)	0.96% (2/208)	0.62% (2/325)	NOT MET

Discussion: The plan did interpret the results, and referenced the changes in percentages from earlier quarters in order to interpret improvement.

Improvement shown? For the intervention tracking measure, comparing Q4 2016 to Q2 2017, the decrease from 1.0% to 0.76% of 'percentage of use of renal AVF observed by the surveillance done quarterly by the Project Leader' does not appear to have shown improvement.

Strengths: Key strengths include:

- The topic selected, use of Arteriovenous Fistula, can result in significant changes in members' health and quality of life.
- The PIP aimed to increase member access to multidisciplinary services that included the following: PCPs and Nephrologist.

Opportunities for Improvement: Key opportunities for improvement include:

- The PIP should include a thorough barrier analysis linked to related interventions.
- Plan-Do-Study-Act (PDSA) worksheets could be used to plan, monitor and interpret progress of key interventions that represent meaningful tests of change.
- Development of interventions for direct member outreach in order to educate members and to facilitate use of renal AVF is merited.
- A more rigorous approach to performance indicator specification, measurement and reporting is indicated.
- Details should be provided on numerator and denominator for the intervention tracking measure.
- In order to have a more robust PIP, it should include actions that target not only the providers but also the members, and the MCO.
- Analysis should include an interpretation of results; only quarterly results were updated in each measurement year. No statements/discussion regarding observed improvement (or lack of improvement) was found.

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to lack of robust set of member and provider interventions.

4. Use & Reporting of Mental Health Services at PMGs

PIP Topic: Mental Health

Study Question/Objectives: The main purpose of the project is to increase the use and reporting of the Mental Health services provided at the Primary Medical Group in support of the *Collocation Model*. The objective of the PIP is to answer the following question: Do the educational interventions for providers implement by MMM Multi Health for the

Collocation project help improve the use and the reporting of the Mental Health services provided at the PMG for members with mental health conditions at the Southeast and Northeast Region in at least 3% by June 30, 2017?

Measurement Period

- Baseline: April 1, 2015 to December 31, 2015
- 1st measurement: January 1, 2016 to September 30, 2016
- 2nd measurement : October 1, 2016 to June 30, 2017

Population: MMM Multi Health currently a *Collocation/Reverse Collocation Model* in place that addresses the integration of physical and behavioral health services. The study population for the Southeast region is a total of 39 providers in charge for the care of members within 3 to 74 years old with a mental health condition. The study population for the Northeast region is a total of 79 providers in charge for the care of members within 1 to 87 years old with a mental health condition.

Methodology/ Performance Indicators: The indicator selected to determine the effectiveness of this project is an internal indicator that will measure the percent of collocated services done among the members of 3 to 74 years old enrolled in MMM Multi Health during the study period. The data source for this indicator is administrative data included in claims/encounters submitted by the providers through the plan's Claim system.

Interventions

Provider interventions:

The main strategy of this project is an Educational Campaign for the providers in charge of members with 1 to 87 years old with MH conditions. The purpose of this strategy is to reinforce the importance and benefits of the MH services at PMG setting through an Educational Campaign for providers. This Educational Campaign will cover the importance and benefits of the MH services in PMGs and the importance of submitting the appropriate coding. The materials of the Educational Campaign consisted of a Power Point presentation including information about key related aspects such as: benefits of the *Collocation Model*, adequate documentation and coding of such MH services and the importance of proper coordination of services. The Educational Campaign is shared with the providers during face to face interventions.

Results: The following table illustrates the 2nd measurement results for the Collocation rate for the Northeast Region.

Study indicator	Baseline result	1st Measurement	2nd Measurement	Expected improvement
Collocation rate	4.6% (3,785/82,010)	9.8% (6,784/68,885)	9.2% (5,237/56,750)	MET

The following table illustrates the 2nd measurement results for the Collocation rate for the Southeast Region.

Study indicator	Baseline result	1st Measurement	2nd Measurement	Expected improvement
Collocation rate	3.5% (2,974/84,961)	7.0% (5,304/75,447)	7.3% ()4,328/59,003	MET

Discussion: The plan did not interpret the results, only referenced the changes in percentages from earlier quarters within the results table.

Improvement shown? The goals associated with the indicator were reached in the first measurement period for both, NE and SE region. No actions were taken to propose a bolder and far-reaching goal for the second measurement period.

Strengths
Key strength includes: Topic rationale demonstrates relevance to the MCO's member population through MCO-specific data.

Opportunities for Improvement: Key opportunities for improvement include:

- A more rigorous approach to performance indicator specification, measurement and reporting is indicated.
- For future PIPs, it is recommended that the plan conducts root cause/barrier analysis
- It is recommended to use findings to inform modifications to interventions on an ongoing basis throughout the course of the PIP.
- The plan can use Plan-Do-Study-Act (PDSA) worksheets to plan, monitor and interpret progress of key interventions that represent meaningful tests of change and, with improved ITM rates, used to spread successes to impact a greater proportion of members.
- Analysis should include an interpretation of results; only quarterly results were updated in each measurement year. No statements/discussion regarding observed improvement (or lack of improvement) was found.
- In order to have a more robust PIP, it should include actions that target not only the providers but also the members, and the MCO.

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to lack of robust set of member and provider interventions.

Molina Performance Improvement Projects

1. Arteriovenous Fistula (AVF) usage improvement Initiative

PIP Topic: Arteriovenous Fistula (AVF)

Study Question/Objectives: To increase AVF usage among Chronic Kidney Disease Stage 4 / End Stage Renal Disease members at risk or in use of hemodialysis

Measurement Period: 4/1/2015 – 6/30/2018
Baseline years indicated: April 2015-December 2015
Subsequent year(s) indicated: Re-measurement #1: July 2016-December 2016

Re-measurement #2: January 2017-December 2017
Re-measurement #3: January 2018-June 2018

Population: Molina estimates there are about 700 adult members with ESRD

Methodology/ Performance Indicators: Members identified were enrolled into case management and/or complex case management for education and referral assistance for AVF consultation.

Interventions
Member interventions:

- Enrolled into case management for education and care coordination on AVF

Provider interventions: none listed

MCO interventions:

- Case management referred cases to provider network department to resolve issues with surgeons refusing to see members
- Case managers confirmed members had a nephrologist and PCP

Results: Indicator #1: The percentage of ESRD members on dialysis who received AVF achieved a project rate of 97.6% (248/254) compliance. This rate is 47.6 percentage points higher than the baseline goal of 50%.

Indicator #2: The percentage of early cardiovascular surgeon referrals to "AVF only" evaluation and timely placement achieved a project rate of 0.05% (13/254) compliance. This rate is 49.95 percentage points lower than the baseline goal of 50%.

Discussion: The MCO interpreted their results by referencing to the changes in percentages from earlier measurement periods, as well as referring to their benchmark rates in order to effectively interpret their outcomes.

Improvement shown? Although there was a decrease between the 1st and 3rd re-measurement periods, Molina demonstrated an overall improvement with a rate of 97.6% in AVF functional usage for ESRD members on dialysis.

Strengths: The health plan conducted ongoing barrier analysis in order to identify interventions.

Opportunities for Improvement

- The MCO should incorporate interventions that target providers
- The time periods in which data were collected were inconsistent from baseline to final measurement. The baseline timeframe was for 9 months, the 1st re-measurement period included 6 months of data, the 2nd re-measurement included 12 months and final measurement was for 6 months. It is best to have comparable time periods, so that rates can meaningfully be compared year over year.

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to changes made after the baseline and the difference in timeframes between each measurement period.

2. Improving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Screening Rates

PIP Topic: EPSDT

Study Question/Objectives: The identified opportunity for improvement is to increase the rate of EPSDT visits, as measured through the following HEDIS measures: Well Child Visits 0-15 Months, Childhood Immunizations, Well Child Visits in 3-6 Years of Age, and Adolescent Well Care Visits. The MCO's goal is to meet or exceed the Quality Compass Medicaid 25th percentile.

Measurement Period
Baseline: July – December 2015
Re-measurement 1: January – December 2016
Re-measurement 2: January – December 2017
Re-measurement 3: January – June 2018

Population: Molina Healthcare estimates that approximately 120,000 members between the ages 0-20 years were impacted by this improvement activity based on enrollment.

Methodology/ Performance Indicators
The following HEDIS measures were collected and analyzed throughout the PIP:

Indicator #1: HEDIS CIS (combo 10)

Indicator #2: HEDIS W15

Indicator #3: HEDIS W34

Indicator #4: HEDIS AWC

Data were collected and analyzed quarterly to monitor progress, as well as annually for reporting purposes. All processes involved during the HEDIS data collection and medical records abstraction were based on the HEDIS specifications and were audited during the HEDIS Compliance Audit. Molina Healthcare uses NCQA-certified software to report HEDIS rates. HEDIS program managers have years of experience reporting HEDIS rates.

Interventions
Member interventions:

- Outbound calls were made to members who had not completed EPSDT preventive services. Staff educated members on the importance of receiving the preventive care services and assisted members with scheduling their appointment.
- Molina's HEDIS Appointment Team (HAT) implemented three EPSDT outreach campaigns to non-compliant members. On average, 75% of members with a valid phone number were reached. Out of those reached on average 41% of appointments were scheduled. Care Management managed 517 members by completing an evaluation and individualized care plan to ensure care and well child visits are discussed and completed.
- Molina partnered with PMGs to coordinate the Cotto Laurel Health Fair. Education materials and EPSDT services were provided, including immunizations.
- Educational brochures were mailed to 4,003 members in 2016, and 517 members in 2017 (the difference in the volume of brochures sent is not understood).
- As part of the prenatal program, soon-to-be moms are educated on the importance of enrolling their new baby in Medicaid and early stage well child visits.

Provider interventions:

- Molina provided care gap reports and EPSDT lists of current non-compliant members to their provider offices.
- Provider engagement visits, which included a discussion of the provider's performance, chart reviews and the distribution of an EPSDT provider toolkit. The toolkit included information on EPSDT requirements, appropriate coding, encounter data submission and the use of standardized charting forms to assist with complete documentation.
- Flyers and communication tools were developed to inform providers of importance, timeframes, and health initiatives for EPSDT.
  Educational sessions were organized monthly by region and offered Continued Medical Education (CME) courses to help providers complete their license requirements.

Results: The MCO reported baseline for the East and Southwest Regions for indicators 1 and 4, however remeasurement rates did not make this distinction. It is not clear if all regions were included, or only the East and Southwest. Baseline rates were not reported for indicator 2 or 3. Final remeasurement data are preliminary, only reflecting the first 6 months of the year. Results are as follows:

- Indicator 1: BL East Region: 0.30%; BL Southwest: 0.10%; Remeasurement 1: 15.50%; Remeasurement 2: 0.70%; Remeasurement 3: 0.55%
- Indicator 2: BL unavailable; Remeasurement 1: 12.00%; Remeasurement 2: 19.31%; Remeasurement 3: 12.64%
- Indicator 3: BL unavailable; Remeasurement 1: 46.57%; Remeasurement 2: 50.90%; Remeasurement 3: 33.19%
  Indicator 4: BL East Region: 19.70%; BL Southwest: 15.60%; Remeasurement 1: 33.60%; Remeasurement 2: 30.20%; Remeasurement 3: 18.23%

Molina Healthcare did not reach the goal of the 25th percentile for any of the quality indicators.

Discussion: The MCO interpreted their results by referencing to the changes in percentages from earlier measurement periods, as well as referring to their target rates in order to effectively interpret their outcomes.

Improvement shown? Results are difficult to interpret, given lack of baseline data for indicators 2 and 3, the fluctuation in rates throughout the project period, and only the availability of preliminary data for the final remeasurement period

across all 4 indicators. The goals associated with each indicator were not reached throughout any of the measurement periods.

Strengths

- Molina worked to actively engaged both members and providers.
- The MCO identified barriers/root cause analysis and planned interventions accordingly.
- The MCO has promising next steps outlines, which include the outreach team contacting non-compliant members on a monthly basis to educate and encourage well-child visits from birth to 21 years of age.

Opportunities for Improvement

- In 2016, Molina cited the inability to match beneficiary information to the Puerto Rico Immunization Registry (PRIR), due to lack of a common identifier. The low rates of CIS-combo 10 (<1%) in remeasurement 2 and 3 suggest there may be an opportunity for better identification of who is being vaccinated, and thus to retrieve data elsewhere and/or work within the registry to identify members by last name.
- It is recommended that the MCO develop and monitor monthly Intervention Tracking Measures (ITMs) for each intervention; identify stagnating or declining ITM monthly trends; conduct root cause/barrier analysis; and use findings to inform modifications to interventions on an ongoing basis throughout the course of the PIP.

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to the variance in time periods that are being compared (only preliminary data available for final remeasurement), as well as unavailability of baseline data for indicators 2 and 3.

3. Improvement in Behavioral Health Inpatient to Outpatient Transitions of Care

PIP Topic: Follow-up after Hospitalization

Study Question/Objectives: This QIP aims to improve the percentage of discharges for members 6 years of age and older who were hospitalized for treatment for selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days and within 30 days of discharge.

Molina did not indicate goals for indicators 1 and 2; only the benchmark (HEDIS 2014 Quality Compass 50th percentile for Medicaid) was provided.

Measurement Period
Baseline: April 2015-December 2015
Re-measurement 1: January 2016-December 2016
Re-measurement 2: January 2017-December 2017
Re-measurement 3: January 2018-June 2018

Population: Molina estimates they are 2,000 members in the eligible population.

Methodology/ Performance Indicators: The following HEDIS measures were collected and analyzed throughout the PIP:
Indicator #1: The percentage of mental health discharges for which the member received follow-up with a mental health practitioner within 30 days of discharge.

Indicator #2: The percentage of mental health discharges for which the member received follow-up with a mental health practitioner within 7 days of discharge.

HEDIS specifications were used to collect data, and were audited during the MCO's HEDIS compliance audit. Molina Healthcare uses NCQA-certified software to report HEDIS rates.

Data were collected and analyzed quarterly to monitor progress, as well as annually for reporting purposes.

Molina requested that their contracted mental health hospitals send a daily census of admitted members, as well as their discharge summaries.

Interventions : *Member interventions:* Molina conducted onsite or telephonic discharge planning for members currently in the hospital. Transition coaches conducted face-to-face or telephone outreach to review discharge plan and medication reconciliation. CM staff served as an appointment coordinator, to assist members in scheduling and following through with their appointments post-discharge. In response to analysis of barriers in 2018, Molina identified additional interventions; member education will be led by the Case Management (CM) and Transition of Care (ToC) team post-discharge. Further, the CM will continue to work with the largest psychiatric hospital in Molina's network to coordinate onsite discharge planning. ToC coaches will ensure comprehensive member information was on file, by confirming/verifying member contact information (in partnership with hospitals, mental health providers, and pharmacies). Coaches will work with UM in order to verify the receipt of mental health services.

Provider interventions: None specified.

Results: Rates were reported for both measures for HEDIS reporting years 2016-2019.

Detailed analysis of results below under "Improvement shown?".

Discussion: The MCO interpreted their results by referencing to the changes in percentages from earlier measurement periods, as well as referring to their target rates in order to effectively interpret their outcomes.

Improvement shown?

Indicator #1: The MCO's baseline rate exceeded measurement periods 1 and 2, however this should be interpreted with caution since the baseline period only contained 8 months of data (as opposed to 12) and did not include numerator and denominator components to be able to effectively interpret the rate (69.0% for East Region and 68.7% for Southwest Region). Although the MCO did not achieve their goal of 75.28%, incremental improvement was shown between interim measurement periods and final re-measurement; 42.68% for interim period 1 (Jan-Dec 2016), 52.39% for interim period 2 (Jan-Dec 2017) and 69.42% for final remeasurement (Jan-June 2018). Note rates were not stratified by region following baseline period. It is assumed the reported rates for interim and final measurement periods represent an aggregate of both regions.

Indicator #2: Similar to indicator #1, the MCO's baseline rate for indicator #2 exceeded measurement periods 1 and 2, however this should be interpreted with caution since the baseline period only contained 8 months of data (as opposed to 12) and did not include numerator and denominator components to be able to effectively interpret the rate (45.7% for East Region and 45.2% for Southwest Region). Although the MCO did not achieve their goal of 56.78%, incremental improvement was shown between interim measurement periods and final re-measurement; 29.34% for interim period 1 (Jan-Dec 2016), 35.08% for interim period 2 (Jan-Dec 2017) and 51.39% for final remeasurement (Jan-June 2018). Note rates were not stratified by region following baseline period. It is assumed the reported rates for interim and final measurement periods represent an aggregate of both regions.

Strengths: Molina carried out ongoing barrier analysis in order to inform interventions. The MCO also pursued active interventions that engaged members.

Opportunities for Improvement

- The MCO should carry out interventions that target providers.
- For future PIPs, it is recommended that Molina develop and monitor monthly Intervention Tracking Measures (ITMs) for each intervention; identify stagnating or declining ITM monthly trends; conduct root cause/barrier analysis; and use findings to inform modifications to interventions on an ongoing basis throughout the course of the PIP. Monthly ITM trends could be monitored using run charts. Plan-Do-Study-Act (PDSA) worksheets could be used to plan, monitor and interpret progress of key interventions that represent meaningful tests of change and, with improved ITM rates, used to spread successes to impact a greater proportion of members.

- The MCO did not provide numerator and denominator components for their baseline rates, thus making interpretation difficult. Further, the time periods in which data were collected were inconsistent from baseline to final measurement (baseline included 8 months of data, interim periods one year, and final measurement 5 months). It is best to have comparable time periods, so that rates can meaningfully be compared year over year.

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to the variance in time periods that are being compared.

4. Primary Care Physician and Behavioral Health Collaborative Care Project

PIP Topic: Depression and Diabetes CoLocation

Study Question/Objectives: To improve health outcomes and reduce the cost of care for members diagnosed with depression and diabetes.

Measurement Period: 1/1/2016 – 6/30/2018
Baseline years indicated: Indicator #1: March 2016 – December 2016
Indicator #2: No baseline years indicated.

Subsequent year(s) indicated: Indicator #1: Re-measurement #1 - Mar 2017 – Dec 2017
Indicator #1: Final re-measurement - July 2017 - June 2018
Indicator #2: Re-measurement #1 – Jan 2016 – Dec 2017
Indicator #2: Final re-measurement – July 2017 – June 2018

Population: Molina has identified an estimated 5,174 members with a diagnosis of diabetes and depression.

Methodology/ Performance Indicators: The MCO utilized two non-standardized measures Improved Health Outcomes Performance Per Capita Cost of Care.

Interventions
Member interventions:

- Member outreach

Provider interventions:

- Collaboration between specialists and Primary Medical Groups (PMG) to obtain accurate member information such as; updated address and phone numbers and diabetic diagnosis
- PCP education

MCO interventions:

- Communication with MCO corporate office to address barriers

Results

Measurement	Baseline	Remeasurement 1	Remeasurement 2	Goal
Indicator 1 – Improved Health Outcomes	Not calculated	73.58%	63.5%	45% of participants scoring 50% or greater improvement in baseline

Indicator 2 – Per Capita Cost of Care	Not calculated	1.48%	2.64%	1% decrease in total cost of care

Discussion: The MCO interpreted their results by referencing to the changes in percentages from earlier measurement periods, as well as referring to their benchmark rates in order to effectively interpret their outcomes.

Improvement shown? Indicator 1: Although the MCO met its goal of 45% of participants scoring 50% or greater improvement in baseline depression scores, the rates decreased from re-measurement #1 to the final re-measurement. Also, it should be noted that the MCO stated the numerator and denominator for the baseline measurement period remained the same and did not have results for this time frame in the data table. Therefore a comparison can only be made between re-measurement #1 and final re-measurement.

Indicator 2: The MCO did not demonstrate an improvement in reducing total cost of care. It should be noted that the MCO did not have baseline data for this indicator and therefore a comparison can only be made between re-measurement #1 and final re-measurement. Also, employee hours were an estimate based on hours submitted by employees which could have varied greatly between the measurement periods affecting the numerator.

Strengths: With the project only active for 11 months due to contract end date and the inability to reach members due to Hurricanes Maria and Irma, the health plan was able to demonstrate an improvement with indicator 1. The health plan conducted ongoing barrier analysis in order to identify interventions. The health plan also included interventions that engaged members, providers and the MCO.

Opportunities for Improvement: The MCO did not provide numerator and denominator components for their baseline rates making interpretation difficult. Further, the time periods in which data were collected were inconsistent from baseline to final measurement. Indicator 1 had baseline and re-measurement periods included 9 months of data and final measurement 11 months. Indicator 2 had no baseline time period and the re-measurement and the final measurements were 11 months. It is best to have comparable time periods, so that rates can meaningfully be compared year over year.

- On the cover page, the per capita cost of care segment of the project should be reported in the “Non-clinical focus area.”
- The MCO does not explicitly state why there is a focus on diabetic members. The MCO should include a statement explaining why diabetes was focused on. Why were other chronic conditions not included?
- The estimation of 5,174 members being impacted by the PIP is drastically different than the actual denominators reported. The MCO should explain why MCO data was not utilized to determine the exact number of adult Molina members with a confirmed diagnosis of diabetes or to identify the diabetic members with a confirmed diagnosis of depression.
- The title of quality indicator #1 is general and does not provide information on what is being measured. It should be revised to describe what is being measured.
- Both the numerator and denominator for quality indicator #1 need to be revised for clarity. There is no mention of the criteria for the diagnosis of diabetes.
- Benchmark for quality indicator #1 is the same as the baseline goal. If the benchmark is unavailable, it should be stated.
- The use of and identification of pilot groups should be described earlier in the report.
- The inclusion criteria does not explicitly state which members are eligible for the sample. For example, age criteria, confirmed diagnoses, primary care at the selected pilot sites?
- The MCO included this statement in the report “The denominator for both, the Improved Health Outcome study indicator and the Per Capita Cost of Care study indicator, remained the same from the start of recruitment to the end of the project,” however, it is inaccurate. The denominators are not the same.
- In regard to quality indicator #2, the benchmark is the goal of the project. If a benchmark does not exist, it should be stated. Shouldn’t the inclusion criteria be the sample population for indicator 1?

- In the data table, it should be clearly stated what is being measured and what is displayed. The information in the data table for indicator 1 does not seem to match what is reported in the analysis section of the report. It is hard to follow what the final denominator counts should be.
- According to the numerator and denominator descriptions for quality indicator 2, the data should be currency.
- The MCO makes this claim without including the evidence to support it, "This improvement has led to members being compliant with diabetes screening, antidepressant medication adherence, and overall improved health outcomes." If the MCO is measuring the success of the PIP based on diabetes screening, medication adherence, etc., the MCO should include indicators to track performance in these areas.

Overall Credibility of Results: Results must be interpreted with some caution due to the absence of baseline data, differences in timeframes between each measurement period, and inconsistencies in the data reported.

Triple-S Performance Improvement Projects

1. Establish and comply with the Reverse Co-location Model in compliance with Reverse Collocation Guidelines as established by ASES

PIP Topic: The plan stated that, "The guidelines establish that a PCP be located in a Behavioral Health Facility at least:
- Ambulatory Services Units must have at least on collocated PCP 4 days per week for 4 hours.
- Addiction Services Units must have at least one collocated PCP 3 days per week for 4 hours.
- Psychiatric Hospitals are required to have at least a PCP on call on a daily basis.
- Partial Hospitalization Units must have at least one collocated PCP 1 day per week for 3 hours.
- Stabilization units must have one PCP for consultation (on call) on a daily basis.

Study Question/Objectives: The plan stated Activity 2.1 as follows: "This project will monitor the implementation and compliance of the Reverse Collocation Model with Attachment 21 of the Agreement between Triple-S and ASES.

Measurement Period: The plan stated Activity 6. Reliably Collect Data as follows: "No, there was no evidence of the validation and the integrity of the data collection process" and "No" to activities 6.2-6.6 "because [each section] was not performed."

Baseline years indicated: No, as indicated above.
Subsequent year(s) indicated: No, as indicated above. The plan did state that April through June 2015 is the implementation period, and that the measurement period will start on July 2015.

Population: The plan indicated that there were 439,215 Medicaid enrollees in MCO; however, responses to 4.1 (The at-risk population is defined) and 4.2 (If the study population includes the entire population, the data collection approach captures all enrollees to whom the study question applies) were stated as "Not applicable".

Methodology/ Performance Indicators:

- Number of Facilities in compliance
- Number of Facilities not in compliance
- % of Facilities in Compliance with Reverse colocation Guidelines; the plan reported that the standard is ≥80%.

Interventions
Member interventions*: None indicated.*
Provider interventions*: The plan states the following for Activity 7. Implement Intervention and Improvement Strategies:*

- *"*Causes and barriers were identified and discussed in the Quality Committee. One BHF did not report the required service hours. Triple S was notified of this finding on September 21. A reverse collocated MD was contracted on October 9 and started services on October 23, 2015."

Results: The facility compliance rate was reported as 98% during Apr 2015-Oct 2018..

Discussion: The plan interpreted that, "Project met specified goals consistently during the previous measuring period."

Improvement shown? Not Applicable. This was not a Performance Improvement Project because the components of a PIP were not addressed and there was not a comparison to a baseline measurement period.

Strengths: This appears to be a compliance report, and compliance does appear to have been attained per the plan's stated results; however, findings do not represent those of an independent EQRO compliance review.

Opportunities for Improvement: Implement a PIP to improve member access to services to integrate behavioral health with physical health.

Overall Credibility of Results: There are one or more validation findings that indicate a bias in the PIP results. This was a compliance monitoring project rather than a Performance Improvement Project.

2. Improve the Adherence of Antidepressant Medication Management (AMM)

PIP Topic: Antidepressant Medication Management

Study Question/Objectives: This PIP focuses on measuring the adherence of GHP patients with a major depression diagnosis and the compliance with antidepressant drugs. The goal is to reach/exceed the HEDIS 50th percentile rate of 49.7% for Effective Acute Phase Treatment and 33.9% for Effective Continuation Phase Treatment.

Measurement Period

Baseline years indicated: HEDIS 2014 (5/1/12-4/30/14)
Subsequent year(s) indicated: HEDIS 2015 (5/1/12-4/30/13), 2016, 2017, 2018, 2019

Population: All GHP patients registered in the Metro North and West over the age of 18 that are newly diagnosed with a Major Depressive Disorder.

Methodology/ Performance Indicators: HEDIS AMM performance measure

Interventions

Member interventions:

- *Pharmacy interventions (not specified)*
- *Supplement member contact information with member telephone numbers provided to the outpatient pharmacy.*

Provider interventions: None other than pharmacy interventions indicated above.

Results: Rates were reported for both measures for HEDIS report years 2014-2019.

Discussion: There was a narrative discussion of improvement strategies that identified incorrect member contact information as the greatest barrier. Narrative discussion of the results also acknowledged an increasing trend, and indicated that the HEDIS 2019 data was affected by a system challenge that was identified and corrective measures established. However, the plan did not specify whether or not the corrective measure is reflected in the HEDIS 2019 rates reported in the submitted PIP Report. In addition, there was no interpretation of lack of improvement relative to the goals.

Improvement shown? Rates for both measures showed an increasing trend from HEDIS 2014-2018, with a substantial decrease for HEDIS 2019, and neither target rate was achieved.

Strengths: The plan identified the barrier of incorrect member contact information and implemented a countermeasure by utilizing telephone numbers given to the outpatient pharmacy.

Opportunities for Improvement:

- Interventions for direct member outreach and engagement by care coordinators to educate members and to facilitate appointments for initiation and continuation of medication is merited.
- Interventions for provider education are also merited.
- For future PIPs, it is recommended that the plan develop and monitor monthly Intervention Tracking Measures (ITMs) for each intervention; identify stagnating or declining ITM monthly trends; conduct root cause/barrier analysis; and use findings to inform modifications to interventions on an ongoing basis throughout the course of the PIP. Monthly ITM trends could be monitored using run charts. Plan-Do-Study-Act (PDSA) worksheets could be used to plan, monitor and interpret progress of key interventions that represent meaningful tests of change and, with improved ITM rates, used to spread successes to impact a greater proportion of members.

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to lack of specification of a robust set of member and provider interventions, as well as the HEDIS 2019 data issue that the plan identified as a system challenge.

3. Improve the Communication between Behavioral Health Providers and PCPs I Co-location Model

PIP Topic: Same as above; however, the PIP does not explain what a "Co-location" Model means in this PIP.

Study Question/Objectives: Section 2.1 regarding the study question was left blank on the PIP template. There were no target rates for improvement set.

Measurement Period: The baseline and comparison years are not clearly and consistently identified. It is not clear why the baseline year is inconsistently defined, i.e., 4/1/14-12/31/15 in Section 9.1 vs. 4/2014-3/2015 in the table, "2016 Results". In the table labeled "2016 Results", it appears that the baseline period covers 12 months (Apr 2014-Mar 2015) but the comparison period covers only 9 months (Apr-Dec 2016). What about the time frame from April 2015-December 2015?

Baseline years indicated: The PIP states, "Baseline period will be measured based on Claims/Encounter data from '04-01-2014' to '12-31-2015'. The baseline period will be calculated once we verify the completeness of the data, we estimate we could perform baseline by the end of December 2015." However, in a table entitled "2016 Results", the plan presented baseline data for April 2014-March 2015, rather than data for 4/1/14-12/31/15.

Subsequent year(s) indicated: The PIP presented a table with April-December 2016 results for comparison of "Percentage of patients with a discussion between the BHP and PCP"; however, as stated above, this is a 9 month time period whereas the baseline is a 12 month time period.

Population: The PIP states, "analyses and interventions will be carried out with Collocated BH Professionals and PCPs. Therefore a sample is not necessary." However, the eligible member population was not defined.

Methodology/ Performance Indicators: The PIP states, "The study will collect, analyze and measure reports including encounter and claims data regarding services codes for case discussions." The PIP also states, "Average discussion per patient of total patient treated at the PMG's by the Behavioral Health Provider" in response to Activity 8.2 Results and findings present numerical data in a way that provides accurate, clear and easily understood information. However, the performance indicators were not specified. No claims codes were indicated to make a valid and reliable measurement of "case discussions".

Further, the plan stated that "A Two Tailed Hypothesis Testing was performed" to compare "The mean score of Number of case discussions per patient for the baseline period" to the "measurement period". First, it is not clear to what "measurement period" this refers. Second, in order to conduct statistical hypothesis testing, the assumption of

independent samples must be met; however, this assumption does not appear to be met because year-to-year comparisons are not independent, as they can include the same members. Nor would a paired sample t-test be appropriate, since each subject was not measured twice.

A PIP that makes year-to-year comparisons of performance indicators interprets improvement by first setting a target rate for improvement over the baseline year rate, then comparing the re-measurement year rate to that target rate to interpret whether or not the targeted improvement was achieved. However, there were no target rates set for improvement.

Interventions
Member interventions: None.

Provider interventions: "Meetings between APS and TSS to evaluate and approve form to improve the communication between behavioral health providers and PCP's. In March, the form will be incorporated into the electronic system."

There were several unanswered questions: Who is APS? TSS? What does co-location mean? In March of what year was this implemented? How would a form help to improve communication if the performance indicator was a case discussion? How were providers educated about how to communicate? How to use the form? How to use the electronic system?

Results: Data for the "Percentage of patients with a discussion between the BHP and PCP" was presented for Apr 2014-Mar 2015 (1.49%) and for April 2015-Dec 2017 (26.2%), with monthly rates for Jan 2017-Dec 2017 of 15.2%-14.0%. Given the decline from Jan 2017 to Dec 2017, the increase from 1.49% from baseline to 26.2% first re-measurement does not seem plausible. Similarly, given the decline from October 2017 to October 2018, the increase from 1.495 at baseline to 31.1% at final re-measurement does not seem plausible.

Discussion: Based upon inappropriate application of hypothesis testing, the discussion interpreted improvement as "the mean case discussion is different than the mean score of the Baseline". In addition, the discussion section in the Figure, "Annual Result 2018" refers to the re-measurement performance indicator as "the mean case discussions", refers to the baseline performance indicator as the "mean score", and presents data in the table as "Percentage of patients with a discussion between the BHP and PCP". Therefore, inconsistent performance indicators were utilized.

Improvement shown? Unable to determine, due to inconsistent and unclear definition of performance indicator, as well as inconsistent and unclear timeframes.

Strengths: Communication between BHP and PCPs is important for developing a comprehensive Plan of Care, for reconciling medications, and for coordinating member care; however, it is not clear what the components of a "case discussion" are and how they would help to improve member care.

Opportunities for Improvement

- Implement member interventions, such as MCO care manager outreach to members to develop a plan of care that integrates behavioral and physical health, and coordinates plan of care development with member, BH provider and PCP.
- Utilize standardized performance indicators that integrate physical health with behavioral health, such as the HEDIS measure, "Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)"/
- Set target rates for improvement based upon baseline rates. Interpret improvement at final re-measurement relative to the target rate.
- The performance indicator use in this PIP would better serve as an intervention tracking measure and used to monitor the progress of a provider intervention to educate providers about conducting and documenting case discussions.

- For future PIPs, it is recommended that the plan develop and monitor monthly Intervention Tracking Measures (ITMs) for each intervention; identify stagnating or declining ITM monthly trends; conduct root cause/barrier analysis; and use findings to inform modifications to interventions on an ongoing basis throughout the course of the PIP. Monthly ITM trends could be monitored using run charts. Plan-Do-Study-Act (PDSA) worksheets could be used to plan, monitor and interpret progress of key interventions that represent meaningful tests of change and, with improved ITM rates, used to spread successes to impact a greater proportion of members.

Overall Credibility of Results: There are one or more validation findings that indicate a bias in the PIP results, most notably, lack of consistent and clear specification and measurement of the performance indicator, lack identification of the eligible member population and lack of any member interventions.

4. Renal Condition PIP: Health care services for PSG patients with Renal Conditions under Special Coverage receiving services with PR Renal Clinic and fistula as treatment option

PIP Topic: The plan indicated the following responses to 1.1 and 1.2:

1.1. "The National Kidney Foundation (NKF), agree fistulas are the best type of vascular access to patients with renal problems."

1.2. Fistula is a recommended treatment for the patients because it has a lower risk of infection and stays functional longer than other treatment options."

Study Question/Objectives: The plan stated the following study questions:

- "Did chronic renal patient are seen by a multidisciplinary team?"
- "Did patients were educated about fistula as a treatment option?"
- "Did chronic renal patients who considered fistulas as a treatment option were referred to an evaluation by a vascular surgeon?"

Measurement Period

Baseline years indicated: Not indicated. Section 6.3 states, "The data will be collected by our Statistical Analyst on a quarterly basis beginning in July 2015; however, the first measurement period reported is 2016 Q1.

Subsequent year(s) indicated: 2016 Q2-2017 Q4

Targeted Improvement: at least 3% increase annually.

Population: The plan indicated the following:

1.3. "The project will include all chronic renal patients under special coverage in the Medicaid population including those with special health care needs-renal stage IV and V receiving services with PR Renal."

4.1 "Our population is (inclusion criteria):

-Medicaid enrollees registered under special coverage identified as 'Chronic Renal' in stage IV and V within PR Renal clinic."

4.2. "All enrollees that fulfill the inclusion criteria will be included."

Methodology/ Performance Indicators: The plan stated the following as measurable indicators:

3.1. "Evaluation of chronic renal patients by a multidisciplinary team. Refer chronic renal patient's candidates to fistula to a vascular surgeon."

3.2. "The change in health status will be measure based on the following indicators among participants:

a) Clinical indicators:

a. Frequency of treatment modalities selected by chronic renal patients.
b. Percent of change between multidisciplinary services offered during the trimester.
c. Unique chronic renal members evaluated by a multidisciplinary team.

d. Unique chronic renal members referred to a vascular surgeon."

Interventions
Member interventions:

- *Education*
- *Telephone calls by nurses to provide follow-up to members*
- *Access to multidisciplinary services*
- *Fistula as treatment option*

Provider interventions:

- *Multidisciplinary services provided*
  Fistula as treatment option provided

Results
- **Table 5** presented quarterly data for 2017, with percentage change for "amount" of "Multidisciplinary services" between current and last quarter presented. Findings showed the following:
- From Q1 to Q2, "Multidisciplinary services" frequency decreased by 54% (127 to 59)
- From Q2 to Q3, "Multidisciplinary services" frequency increased by 231% (59 to 195)
- From Q3 to Q4, "Multidisciplinary services" frequency increased 2% (195 to 198)

Discussion: The plan interpreted the 2% increase from 195 members to 198 members with "multidisciplinary services offered" as a statistically significant improvement in member access to multidisciplinary services; however, the plan did not interpret the improvement in relation to the 3% targeted improvement, and statistical hypothesis testing is not appropriate for trend comparisons as the samples are not independent. The discussion did address barriers, with planned and implemented improvement strategies to address these barriers.

Improvement shown? It is not clear that the 2% improvement represents clinically meaningful improvement as this only represents an additional 3 members with improved access, and it was not documented whether or not they underwent the Fistula procedure, only that they were offered multidisciplinary services.

Strengths

- The PIP aimed to increase member access to multidisciplinary services that included the following: Internist, Nephrologist, Nutritionist, Social Worker, and conducted quarterly monitoring of the number of members who were offered these services.
- The number of patients evaluated by a multidisciplinary team was also monitored.
- Member education about the availability and benefits of Fistula as an evidence-based treatment was conducted.
- Other quarterly indicators included referrals to Vascular Surgeon, patients that accepted Fistula as treatment, and kidney transplant.
- The plan identified barriers and improvement strategies to address those barriers.

Opportunities for Improvement

- Use a clearly defined, accurate (valid) and consistently measureable (reliable) annual performance indicator, such as the percentage of eligible members who were evaluated by a multidisciplinary team. Define the numerator and the denominator.
- Report data on the annual performance indicator for a baseline year period; set a target rate for that annual performance indicator based upon a bold, feasible goal and a robust set of member and provider interventions.
- Implement new interventions for provider education, as well as for member outreach, education, referral, appointment scheduling and transportation after the baseline year; and compare subsequent years to the baseline year. Interpret improvement in terms of whether or not the target rate was met.

- For future PIPs, it is recommended that the plan develop and monitor monthly Intervention Tracking Measures (ITMs) for each intervention; identify stagnating or declining ITM monthly trends; conduct root cause/barrier analysis; and use findings to inform modifications to interventions on an ongoing basis throughout the course of the PIP. Monthly ITM trends could be monitored using run charts. Plan-Do-Study-Act (PDSA) worksheets could be used to plan, monitor and interpret progress of key interventions that represent meaningful tests of change and, with improved ITM rates, used to spread successes to impact a greater proportion of members.

Overall Credibility of Results: There are one or more validation findings that indicate a bias in the PIP results. Interpretations of improvement are limited for several reasons. First, the performance indicator was measured as an amount rather than as a rate. Second, statistical testing was inappropriately applied to samples that were not independent. Third, performance was not measured and compared on an annual basis, nor were comparisons to the target rate made in order to interpret improvement.

5. Well Child Visits

PIP Topic: EPSDT/ Well Child Visits

Study Question/Objectives: The plan defined the study question as follows:

- Did the infants between 0-15 months have at least one well child visit?

Measurement Period

Baseline years indicated: Inconsistent methodology was reported regarding study timeframes; however, consistent periods are presented for findings during Q1-Q3 2015, 2016, 2017 and 2018; therefore, the baseline time period is interpreted as Q1-Q3 2015. This includes the intervention period, so confounds interpreting any improvement as attributable to the interventions, as interventions must be implemented after the baseline measurement period..

Subsequent year(s) indicated: As above, subsequent measurement periods are interpreted as Q1-Q3 2016, 2017 and 2018.

Population: The plan defined the at-risk population as Medicaid enrollees aged 0-15 months.

Methodology/ Performance Indicators: The plan stated the study indicator as follows: “Well child visit defined as percentage of members who turned 15 months old during the measurement year and who had the following number of well child visits with a PCP during their first 15 months of life…The project will incorporate as indicator the HEDIS measure named Well Child Visit and will represent the percentage of members who were identify as percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life.” The plan also appears to refer to the HEDIS W15 measure “W-15” within the barrier statement, “Lack of EPSDT and W-15 preventive visits members’ education.”

Interventions

Member interventions (as stated by the plan):

- “Education efforts directed to the enrollees.”
- “Coordination of educational workshops and Health Fairs with the inclusion of well child visit.”
- “Telephone calls by Demand management staff to (orient) parents of the importance of the preventive visits, and follow up of the well child visit appointments”.

Provider interventions:

- “Development of Dedicated Preventive Care Centers for provision of well child visits”.
- “Include Well Child Visit related topics in the Continued Medical Education activities.”

Results: The plan presented quarterly data from Q1 2015-Q3 2018 for the percentage of children < 1 year of age, rather than specifying the HEDIS W15 measure that applies to children aged 15 months and younger, as stated in the objective.

Discussion: The plan did interpret the results, and referenced the changes in percentages from earlier quarters in order to interpret improvement, but did not set target rates, so did not interpret improvement relative to target rates.

Improvement shown? Comparing Q3 2015 to Q3 2018, the increase from 26.40% to 58.66% of 'children age less than one year with preventive visits' does appear to have shown improvement.

Strengths: The plan implemented a robust set of interventions that included telephonic and community event member outreach, as well as the development of dedicated preventive care centers.

Opportunities for Improvement:

- A more rigorous approach to performance indicator specification, measurement and reporting is indicated.
- The baseline measurement period must precede the initiation of interventions in order to attribute performance improvement to the interventions.
- For future PIPs, it is recommended that the plan develop and monitor monthly Intervention Tracking Measures (ITMs) for each intervention; identify stagnating or declining ITM monthly trends; conduct root cause/barrier analysis; and use findings to inform modifications to interventions on an ongoing basis throughout the course of the PIP. Monthly ITM trends could be monitored using run charts. Plan-Do-Study-Act (PDSA) worksheets could be used to plan, monitor and interpret progress of key interventions that represent meaningful tests of change and, with improved ITM rates, used to spread successes to impact a greater proportion of members.

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to inconsistent specification of the performance indicator and measurement periods, as well as the overlap of the intervention period with the baseline measurement period.

Medicare Advantage (Platino) PIPs/QIPs

This section of the report presents the results of IPRO's evaluation of the Medicare Advantage (Platino) performance improvement projects (PIPs/QIPs) submitted by Constellation, Humana, MCS, MMM/PMC Platino, and Triple-S Platino for the contract period 2016–2017. The assessment was conducted using a methodology developed by IPRO and consistent with CMS EQR protocols for PIP Validation.

Table 33: Summary of Platino PIP/QIP Projects

Plan	PIP	PIP Measurement Years
Constellation	Reducing All-Cause Hospital Readmissions	2016 - 2017
Humana	Improve Health Outcomes by Promoting Effective Communication and Coordination of Care	Proposal only
	Improving Post Discharge Care Coordination from Hospital	2015 - 2016
MCS	Promote Effective Management of Chronic Disease: Management of Chronic Kidney Disease Stage 4 to Delay Progression of Condition	2017
	Readmission Prevention Program	2015 - 2016
MMM/PMC Platino	Promote Effective Management of Chronic Disease: Osteoporosis Management in women	2016 - 2017
Triple-S Platino	Reduce Hospital Readmissions for COPD Exacerbations	2017 - 2018

Constellation Performance Improvement Projects

1. Reducing All-Cause Hospital Readmissions

PIP Topic: Reducing All-Cause Hospital Readmissions among the Dual Population

Study Question/Objectives

To reduce the re-admission rate of the Dual Population from 19.3% to 16.7%

Measurement Period

Baseline years indicated: CY 2015
Subsequent year(s) indicated: CYs 2016 and 2017

Population: Dual eligible population; n=1,287

Methodology/ Performance Indicators: HEDIS Plan All Cause Readmissions (PCR)

Interventions

Member interventions:

- Post-discharge call within 48-72 hours to the member for follow-up.
- Best practice: Health Plan case managers initiated interventions during the discharge planning process.
- Best practice: Community Outreach Service referrals: Community outreach personnel visit members upon referrals to assess the home environment in order to detect and address poor family support, transportations issues, and other barriers to recuperation.

Provider interventions:

- Pilot project for high-level utilizers where biomonitoring devices are used for monitoring in their homes, complemented with follow-up calls to the members' PCPs.
- Post-discharge call within 48-72 hours to the PCP for follow-up
- Use of technology applications to solidify the physician relationship with the plan.

MCO interventions:

- The plan reinforced the customer service process to confirm and correct demographic information of enrollees during calls.
- Case Managers initiated direct outreach to hospitals on a daily basis to identify admissions in a timely manner, and to provide continuous follow-up and QIP intervention eligibility.
- The plan enabled a direct line for health plan case managers to communicate with hospital discharge planners.

Results

- For members aged 18-64, the PCR rate decreased from 15.70% in 2015 to 11.80% in 2017.
- For members aged 65 and older, the PCR rate decreased from 15.28% in 2015 to 12.04% in 2017.

Discussion: The Plan attributed their improved PCR rate to the multiple initiatives, such as weekly case discussion with the Interdisciplinary Committee, Community Outreach Program referrals, and mental health assessment in the home setting. The plan learned that it is productive to consider the ideas of the Clinical Affairs Department staff, and that it is important to assess interventions continuously in order to measure effectiveness and identify flaws without delay. Next steps were identified to: continue the project as part of the Chronic Care Improvement Program; *Pilot project for high-level utilizers where biomonitoring devices are used for monitoring in their homes, complemented with nurse visits and follow-up calls to the patient and PCP; and a new improvement project was started to reduce the rate of visits to emergency rooms.*

Improvement shown? Yes, the PIP exceeded the targeted PCR rate reduction.

Strengths: The plan implemented member, provider and health plan interventions to ensure timely follow-up with the PCP and community support.
Opportunities for Improvement

- The plan targeted high utilizers, so the range of intervention receipt ranged from 2% to 5%. The pilot project should seek ways to spread successes so that a greater proportion of members receive the interventions. The plans should consider utilizing a Plan-Do-Study-Act (PDSA) worksheet to monitor intervention progress, as explained in the next bullet, and spread successes to impact a greater proportion of members.
- The plan indicated that a lesson was learned regarding the importance of continual monitoring of progress of interventions in order to address problems as soon as possible. Therefore, it is recommended that the plan develop and monitor monthly Intervention Tracking Measures (ITMs) for each intervention; identify stagnating or declining ITM monthly trends; conduct root cause/barrier analysis; and use findings to inform modifications to interventions on an ongoing basis throughout the course of the QIP/PIP.

Overall Credibility of Results: There were no validation findings which indicate that the credibility of the PIP results is at risk.

Humana Performance Improvement Projects

1. Improve Health Outcomes by Promoting Effective Communication and Coordination of Care

PIP Topic: Promote effective communication and coordination of care

Study Question/Objectives: The plan stated that the objective is to promote effective communication and coordination of care. Reach NCQA Quality Compass 50th percentile for HEDIS measure Follow-Up after ED Visit for People with High-Risk Multiple Chronic Conditions (FMC).

Measurement Period
Baseline years indicated: CY 2017
Subsequent year(s) indicated: N/A (the proposal is reviewed here)

Population: Target population for inclusion are members diagnosed with two or more high-risk multiple chronic conditions including: COPD and asthma, Alzheimer's disease and related disorders, chronic kidney disease, depression, heart failure, acute myocardial infarction, atrial fibrillation, or stroke and transient ischemic attack who visit the emergency department.

Methodology/ Performance Indicators: Follow-Up After ED Visit for People with High-Risk Multiple Chronic Conditions (FMC).

Interventions
Member interventions: Enrollee outreach after ED visit. Members having two or more of the identified chronic conditions prior to the ED visit will have an outreach or follow-up service within 7 days following the ED visit. Outreach includes: outpatient visit, behavioral health visit, telephone visit, transitional care management services, case management visits, and complex care management services.

Results N/A

Discussion N/A

Improvement shown? N/A

Strengths The plan is proposing an active intervention involving direct outreach to members.

Opportunities for Improvement

- For future PIP/QIPs, it is recommended that the plan conduct a barrier analysis to inform the development of interventions.
- For future PIP/QIPs, it is recommended that the plan develop and monitor monthly Intervention Tracking Measures (ITMs) for each intervention; identify stagnating or declining ITM monthly trends; conduct root cause/barrier analysis; and use findings to inform modifications to interventions on an ongoing basis throughout the course of the PIP/QIP. Monthly ITM trends could be monitored using run charts. Plan-Do-Study-Act (PDSA) worksheets could be used to plan, monitor and interpret progress of key interventions that represent meaningful tests of change and, with improved ITM rates, used to spread successes to impact a greater proportion of members.

Overall Credibility of Results: Only the proposal is reviewed and so a determination of the credibility of results cannot be made.

2. Improving Post Discharge Care Coordination from Hospital

PIP Topic: Improve post discharge process for members discharged from the hospital.

Study Question/Objectives: Improve post discharge coordination of care for members 65 years old and older. Reduce plan all cause readmission rate 3% over 3 years.

Measurement Period

Baseline year indicated: 2014
Subsequent year(s) indicated: 2015, 2016

Population: Enrolled members 65 years and older discharged from hospital to home. Members discharged to SNFs and rehab facilities are excluded.

Methodology/ Performance Indicators: Internal clinical care management systems used to identify the number of eligible members contacted post discharge, and the number of members contacted within 3 business days of discharge. Claims data was used to track readmission rate.

The performance indicator was Plan all cause Readmission rate.

Interventions

Member interventions: Members discharged to home receive outreach by phone within 3 business days to close any identified gaps in care. This includes 3 outreach attempts within 21 business days to complete post discharge assessment. Elements evaluated during assessment include: discharge planning confirmation, understanding of discharge planning, follow appointment scheduled, medications ordered upon discharge, identification of barriers to care, identification of adequate outpatient support. Discharge report will be available on a daily basis to identify members with an inpatient discharge.

Starting 2015 (Q3) a home health care vendor was contracted to perform home visits to members that met the criteria for 20 diagnoses that have been identified with a high prevalence of readmissions. Members were contacted by a nurse within 48 hours of discharge to complete an initial assessment of factors leading to potential readmission. Follow up calls to members made by post discharge care coordination team. Weekly reports provided by home health care vendor.

Concurrent Review Nurses were used to validate member phone number at time of admission.

In 2016 due to an increased in SNP population the post discharge care coordination interventions were assigned to all the care management team instead of the PDCC team.

Results: Readmission rate 2014 (baseline) = 5.8%, 2015 = 9.63%, 2016 = 15.7%

Initial one year goal for the readmission rate was 10.5%. This was set using data from first half of 2014. Complete data from 2014 indicated that the readmission rate was much lower (5.8%) than the goal.

2015: 76.92% of members identified for inclusion in the post discharge intervention were contacted.

2016: Post discharge care within 10 days of discharge = 70.8%.

Discussion: The plan notes that the contract was new in 2014 with a membership of 2,932. During 2015 membership increased to 4,927, and in 2016 the population increased to 22,869. This new membership may have altered the expected readmission rate.

Improvement shown? No

Strengths

- The plan conducted a strong intervention involving direct outreach to members.
- Post discharge contact rates were assessed monthly. Issues associated with unreachable members were identified and addressed when identified.

Opportunities for Improvement

- Tracking the number of members who received the post discharge intervention serves as an intervention tracking measure. What counts as a successful intervention for this tracking measure changes from year to year. A consistently measured intervention tracking measure would help to track the success of the intervention.
- For future PIP/QIPs, it is recommended that the plan conduct a barrier analysis to inform the development of interventions. Note: barriers to the success of identified intervention were considered.

Overall Credibility of Results: There are one or more validation findings that indicate a bias in the PIP results. While the interventions seem to be strong, the nearly 700% increase in the size of the population over the duration of the PIP make it difficult to identify whether the intervention was or was not effective.

MCS Performance Improvement Projects

1. Promote Effective Management of Chronic Disease: Management of Chronic Kidney Disease Stage 4 to Delay Progression of Condition

PIP Topic: Chronic Kidney Disease

Study Question/Objectives: The report begins with a clear concise problem statement and grounds the study in public health data and clinical practice guidelines and its own member data.

The report provides a clear primary objective – At the end of three years the project goal is a 25% reduction in progression of the subject population from CKD Stage IV to Stage V or ESRD. There is a clearly defined baseline, including numerator, denominator and rate. The data source is identified as is the target population.

The report also lays out a secondary goal to reduce readmissions and ER visits. The report provides baseline rates for the secondary goal but does not provide the numerators and denominators.

Measurement Period

Baseline years indicated –

The baseline period indicated is 2015

Subsequent year(s) indicated –

It appears that the measurement period for this report is 2017. The report is titled 1st year annual update. It is unclear if there is data for 2016.

Population: Total Population: 96,446
Number of Enrollees who received intervention(s): 252
Number of Enrollees who were Eligible to Receive Intervention(s): 520

The plan states that they had 9,931 (denominator) members with CKD Stage IV in the baseline year of 2015 with 804 transitioning to Stage V (numerator) for a rate of 8.1%. In the measure year of 2017 the plan shows a denominator of 199 members with Stage IV Chronic Kidney Disease. There is no discussion of the discrepancy in population's sizes.

The description of population for the secondary outcome measures are less clear as presented in the narrative. The use of tables would greatly simplify and clarify the results.

Methodology/ Performance Indicators

Methodology
The methodology proceeds from a discussion of standard clinical practices to planned interventions.

The plan has clearly defined interventions in place, which involve care management engagement, education and creation of individual care plans for each member in the target population. The project has clearly defined intervention tracking measures as well. These include enrolling target members in the care management process, care manager follow-ups during the subject period, care manager coordination with nephrologists and numerous screening measures.

Data to monitor the percentage of members who received interventions was gathered from data uploaded to CCMS.

Performance Indicators: Indicators include the identification of the target population, the rate of enrollment in the program the incidence of progression from Stage IV to Stage V Kidney Disease and the rates of ED usage and readmission pre and post program implementation.

Interventions
Member interventions:

1. Care coordination – The Care Managers (CM) contacted the target population (TP) by phone within 30 days of identification, and conducted an assessment focused on individual risk factors for CKD progression and related complications (100% (252/252) of PP had an assessment). The CM developed an ICP to outline actions that address needs and barriers identified in collaboration with the member to promote engagement, self-empowerment and decision making regarding health care.
2. Enrollee education – The CM completed follow-up and monitored the member's health status, educational interventions, and conducted care coordination. During the 6 months of participation, the CM would perform at least 4 contacts for follow-ups with the member or caregiver.
3. Disease management – The Care Managers were to coordinate with the Nephrologists and educate members to be evaluated by a vascular surgeon to ease the transition for replacement therapy, as well as for transplant evaluation. Members were excluded for this intervention if they reported a fistula placed, having a vascular surgeon or transplant evaluation of fewer than 6 months, or known as non-candidate for fistula placement or transplant.

Results: The Other Data or Results section of the report was very dense and contains inconsistencies. This information could have been presented in a clearer format, such as a chart.

In section H1 of the report the plan appears to have flipped the placement of the numerator and denominator for intervention tracking measure #1 (cells H1b and H1c), although it is reporting the correct rate.

Primary Goal:

The primary goal was reported to have been achieved for the 252 Special Need Plan (SNP) members participating in the program as of Q3, 2017:

- Section H1d. Results and/or Percentage:
    - For Q1-Q3, the percentage of participants that progressed to CKD stage V and ESRD was 1.5% (3/199). As noted above in the population section, the denominator of 199 is vastly different from the baseline value of 9,931. The reported reduction of 81% in the post program measurement surpasses the goal of a 25% reduction from the baseline of 8.1%.

Secondary Goals:
MCS reported the Secondary goal to achieve a 10% reduction on admissions was met and 10% reduction on ER visits was not met.

The overall percentage of change for admissions was -12.28% and for ED visits was -5.19%. The baseline measures were 9.81% and 31.56% respectively. While it is true that program members show reduced pre and post admission rates based on six months of participation, the post program rate of 25.13% is still significantly higher than the baseline rate reported of 9.81%. Similarly, the plan reports missing the target for ED visits but does not address the increase from baseline at 36.68% v. 31.56%.

Discussion: The discussion section brings in variables outside those described in the goal and intervention sections, aside from a brief discussion of the screening and prevention interventions such as vaccination and care management assessments. The discussion should focus on tying the outcome results to the interventions and recommendation for ongoing changes to the program to achieve results.

To measure the efficacy of the interventions, the plan may consider reporting the percentage of progression to CKD Stage V and ESRD for PP with CKD who were referred, but did not participate in the program.

Interventions that address the gaps in care regarding routine laboratory testing were also reported to be significant in identifying and addressing in an early stage any further complications related to the condition. This suggests that the interventions had a positive impact in delaying the progression of the condition for the participating members.

The fact that the ICP is discussed with and created in collaboration with the member shows a dedication to further educating and empowering the member. Perhaps a focus in the future could be on further educating members how and where to seek treatment, as many (75.0%) cite the availability of comprehensive services as their reason for going to the ER instead of a provider.

Improvement shown? The reported results showed a significant improvement in reduced progression rates for the selected group of program participants.

Although improvement was reported for the Secondary goal of a 10% reduction in admissions, the data are unclear.
The Secondary goal of a 10% reduction in ER visits was not met.

Strengths: There was a strong emphasis on individualized care management.

The plan provided a good explanation of purpose and perceived benefit.

The structure of the report was easy to follow logically from Goals, to Processes, through to Results and Barriers/Mitigation of said barriers.

The report provided an excellent explanation of actions taken by MCS to mitigate barriers. The next steps section is a good reflection on how to continue the positive results seen.

Opportunities for Improvement: Presenting the actual number of PP who experienced progression would allow for accurate calculation of the program's benefit. As CKD is progressive, a longer measurement period may be considered to determine long-term results of these interventions.

The plan established 17 intervention tracking measures. This is a very large number. It is unclear from the discussion of results which of the interventions impacted the outcomes and therefore should be continued.

In several places in the report numerators and denominators are transposed.

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to a lack less than half (48.5%) of members referred participated in the program. It is unclear how the denominator of 199 was determined for the first Goal measures.

2. Readmission Prevention Program

PIP Topic: The plan did not include a Topic/Rationale section in their report.

Study Question/Objectives: There are two outcome measures tracked – Readmissions for a group of 248 members participating in the plan's Readmission Prevention Program and the HEDIS Measure "Plan All-Cause Readmission (PCR)". This is an inverse measure.

The state goal for the first measure is a 25% reduction in readmission in the program group after 30 day participation v. their pre-program rate.

There is no stated goal for the HEDIS measure.

Measurement Period

Baseline years indicated:

For the Readmission Prevention Program it is unclear what the baseline period for the study is. It appears, that the baseline period for this goal is 2014 however no data for the baseline year is reported.
For the HEDIS measure the baseline year is calendar year 2012

Subsequent year(s) indicated

For the Readmission Prevention Program the report cites measurements Q1-Q3 2015, which appears to be an interim measurement. The final measurement period for the study is Quarter 1-3 of calendar year 2016.
For the HEDIS measure the final measurement year is calendar year 2015.

Population: The plan states that they have 88,281 members.

- 400 members were eligible to receive the intervention (compared to 629 in 2015)
- 248 actually received the intervention in 2016 (compared to 330 in 2015)
- The report contains no information on how the population was identified, what criteria were established for eligibility or any exclusions if applicable.

Methodology/ Performance Indicators: The plan has clearly defined interventions in place however the population is defined in terms of numbers but not what criteria for eligibility were utilized.
The plan does not present clear definitions of the measurement periods presented.
The plan does not clearly define the methods used for collecting data for its program participants.

Interventions

Member interventions:

1. 248 members were referred to participate in the Readmission Prevention Program which appears to be a 30 day cycle of interventions. It is not clear from the PIP report how those referrals were made, what criteria were used in selecting members for referral or what the contents of the Program were. These 248 members were supposed to receive the following interventions:

a. Members who agree to participate were required to complete a Readmission Prevention Program Assessment within two days of discharge. It is not clear from the report whether that assessment was completed with the help of a care manager or if the member completed it on their own.
b. Members were offered home visits by a community outreach technician from the MCS care management team.

2. The PIP report provided a confusing citation of 1,114 planned interventions related to their second intervention – "Percentage of members with four (4) or more follow-up". Again it is unclear if this is care management follow-up or this is follow-up visits with a provider. Then the plan reported a rate for this metric based on the universe of 248 members in the program. The plan also reported a rate of participating members new to the program who received a comprehensive general assessment within 30 days and percentage of members referred to another Care Program for those same new cases. The plan provided no discussion of benchmark rates for any of these measures.
3. The final reported intervention was called – "Percentage of Members Participating in the program perceived by them or care manager unstable and unable to access an outpatient facility with a physician's home visit during the 30 days post discharge". The plan provided a rate of 0 based on a denominator of zero (no members deemed unstable). It is unclear why the plan did not use the same denominator of 248 members in the program. This metric had no discussion of an intervention or method of assessment.

Results: For the first outcome measure (reduced readmission for program participants) the plan reports a post-program readmission rate of 42.3% in the 2016 measurement period. This is reduction of 53% against a pre-program rate of 90.7%. This exceeds the goal of 25% reduction. The report also demonstrates a reduction of 68% during the 2015 measurement period. There is no discussion of why the 2016 results are lower than 2015. The plan did meet its goals for both interim and final reporting periods.

The report has a miscalculation in the baseline rate for HEDIS PCR measure. The plan reports baseline numerator of 441 and denominator of 3524. The plan reports their baseline rate as 12.22% however the correct calculated rate would be 12.51%. Therefore the change from prior year is an increase of 4.3% as opposed to the plan's reported increase of 6%. This measure, as stated above, is an inverse measure so an increase in the rate signifies a decline in performance. In addition, the plan does not indicate anywhere in their PIP report what the target decrease for this metric was at the initiation of the project.

The PIP report has a discussion of the results in intervention tracking measures with rates for 2015 however they report does not present the numerators and denominators for those rates. Also, there are no prior rates reported at all for three of the intervention tracking measures; a) percentage of members referred, b) percentage of program participants with a home visit from a community outreach technician and c) percentage of new program participants referred to another care program at the end of the 30 day readmission prevention program.

Improvement shown? The reported results showed a significant improvement in reduced readmission rates for the selected group of program participants. Of the 248 plan participants, the plan reports a 53% reduced readmission rate after completing the 30 day prevention program. HEDIS PCR rates as a whole worsened during the same period, evidenced by a 4.3% increase in the percent of all-cause readmissions.

Strengths: The interventions chosen, which focus on early engagement with care management and regular follow up after discharge, appear to have a significant impact on the outcome of reducing readmissions through participation in the MCO prevention program. The plan is using HEDIS data and benchmarking against national mean rates.

Opportunities for Improvement: There is no clear objective or aim statement in this report. The report jumps right into results without presenting any context for the reader on why this topic was selected. MCS should include their clinical or administrative rationale for selecting this project. The aim statement should include the potential for meaningful impact on member health outcomes, a clear discussion of the initial goals for the project, specific targets for measurement. The plan should include barrier analysis specific to this population to indicate why these specific intervention were chosen.

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to the absence of specific prior year data and the fact that there appears to be some variation in the manner in which data was collected and presented.

MMM/PMC Platino Performance Improvement Projects

1. Promote Effective Management of Chronic Disease: Osteoporosis Management in Women

Plans: MMM DSNP – 033**,** MMM DSNP – 021**,** MMM DSNP – 017**,** PMC DSNP – 048

PIP Topic: Education of members about Osteoporosis

Study Question/Objectives: The plans states that the objective were to raise awareness of Osteoporosis among women at risk, and to improve the management of the conditions in order to lower the risks of further complications that might result in fractures.

Goals include: Reaching at least 30% of enrolled women 50 years and older, through targeted interventions. Increase Osteoporosis Management in Women with Fractures (OMW) by 5 percentage points for HEDIS 2017 (MY2016) in order to receive a CMS 4 star rating.

Measurement Period

Baseline years indicated: 2014
Subsequent year(s) indicated: 2016, 2017

Population

Women 50 years and older enrolled in plan.
2016 update also describes the population as women 65-82 years.
2017 update only describes population as women 65-82 years.

Methodology/ Performance Indicators

Performance indicator 1: The percentage of women 50 years and older enrolled in the plan who were reached by interventions.
Performance indicator 2: HEDIS measure Osteoporosis Management in Women with Fractures (OMW)

Interventions

Intervention 1: Awareness and education campaign. 5 month targeted workshop regarding all osteoporosis topics, from definition of the condition to importance of screening and nutrition. Target population is contacted by phone to participate. Follow up of attendee will be completed. Pre and posttest of knowledge are completed.

Intervention 2: Automated reminder calls to population about the importance of osteoporosis management.

Intervention 3: Individual interventions offered to care managers (nurses) and will be completed with women of the target population that are identified as non-compliant with OMW measure. The individual intervention will be focused on notifying members PCP about member's noncompliance through letters (uploaded in provider's portal), members will also be notified through educational phone calls.

Intervention 4: (introduced 2016): Mobile app focusing on falls, fracture prevention, preventive screening, and appropriate treatment for osteoporosis education.

Intervention 5: (introduced 2017): Phone education to members who did not show to education workshops

Intervention 6: (introduced 2017): Tai Chi exercise program

Intervention 7: (introduced 2017): 303 DEXA screenings to homebound members

Intervention 8: (introduced 2017): Educational articles regarding osteoporosis management and compliance were published in member and provider newsletters.

Intervention 9: (introduced 2017): Gaps in care reports were shared with providers on a monthly basis showing member compliance with OMW.

Results

Performance indicator: Osteoporosis Management in Women with Fractures (OMW)

Baseline: HEDIS 2015 (MY2014) = 39.76 (MMM)

2016: not reported

2017: not reported

Intervention tracking measures

2016

Intervention 1: 17% participated in workshop (MMM/PMC)

Intervention 2: 17% of members received automated calls with educational messages (MMM/PMC)

Intervention 3: 44% (MMM), 54% (PMC) of women received intervention

2017

Intervention 1: 47% of MMM and 53% of PMC target population participated in workshops

Intervention 2: 100% of members received automated calls with educational messages (MMM/PMC)

Intervention 3: 74% of non-compliant women received intervention (MMM/PMC)

Intervention 4: N/A

Intervention 5: 85% (MMM/PMC)

Intervention 6: 48% (MMM/PMC)

Intervention 7: N/A

Intervention 8: N/A

Intervention 9: N/A

Discussion: The plan identified that over 100% of the target population had received at least one intervention. The plan reports that they are waiting for the HEDIS 2018 (MY2017) in order to see the progress of the OMW performance indicator. The original report identifies the goal rate as OMW for HEDIS 2017.

Improvement shown? Unable to determine as performance indicator is not reported after baseline.

Strengths

- The plan worked to actively engaged both members and providers.

- Intervention tracking measures were used to assist evaluation of interventions

Opportunities for Improvement

- The percent of women reached by interventions should have been considered a tracking measure and not a performance measure.
- The age range measured throughout the QIP should remain consistent. The target age group changes from 50+ to 65 – 82 years old in the 2016/2017 reports.
- The rate for the performance indicator, Osteoporosis Management in Women with Fractures should be reported each you to track improvement
- For future PIP/QIPs, it is recommended that the plan conduct a barrier analysis to inform the development of interventions.

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to changes in the age cohort. In addition, the performance indicator is not reported; therefore, it is not possible to interpret whether the interventions resulted in any improvement.

Triple-S Platino Performance Improvement Plans

1. Reduce Hospital Readmissions for COPD Exacerbations

PIP Topic: The QIP describes how "Effective follow up at discharge, care planning and management of medications can improve how patients with COPD deal with the burden of their disease, identify potential exacerbations and subsequently reduce the need for hospital admissions."

Study Question/Objectives: The goal is to "Achieve a 2% reduction in readmissions for patients with COPD/Asthma."

Measurement Period

Baseline years indicated: MY 1: 2016, with January –June 2016 comprising the pre-intervention period.
Subsequent year(s) indicated: MY 2: 2017; MY 3: 2018.

Population: The eligible population includes members "who experienced a discharge for COPD/Asthma", with number of members presented separately in each of the five QIPs.

Methodology/ Performance Indicators

- The timeframes for the numerator and denominator do not overlap, are not restricted to members with COPD admissions and readmissions, and it is not clear whether members or readmissions are being counted. The plan indicated that the numerator would be based upon readmissions that are not COPD-specific within 30 days during CY 2016, but the wording does not clarify whether or not this is a HEDIS measure and whether or not the unit of analysis is members with a readmission or readmissions. Further, the denominator is defined as inpatient admissions with at least one readmission, again, not COPD-specific, within 30 days for CY 2015. Yet, the eligible population was stated as members who experienced a discharge for COPD/Asthma"; therefore, the performance indicators are not specified in a manner that is consistent with the statement of the eligible population.
- Below is an excerpt from the QIP:

"Numerator- Number of for COPD identified by ICD10 during CY2016 who presented a readmission (not COPD specific) within a 30 day period.
Denominator-All acute inpatient admissions from beneficiaries with at least one readmission within 30 day, (not COPD specific) for CY2015.
Exclusion cases-Admissions not registered, Admissions to a Skilled Nursing Facility (SNF) or Rehabilitation facility, Admissions for Pregnancy, childbirth, and puerperium, as a primary diagnosis, admissions with Cancer as a primary diagnosis.

Data Source - Registered admissions and Claims data."

Interventions: The intervention is stated in Section E2a as "Coordinate care transitions by Case Managers for members who experience readmission for diagnosis of COPD/Asthma" and in Section E2b as "Coordination of follow up visits with PCP within 2 weeks of discharge"; however, if the aim of the PIP is to reduce readmissions, this intervention should be targeted to members upon their index (first) admission.

Member interventions:

- Coordination of follow up visits with PCP within 2 weeks of discharge.

Provider interventions:

- Medication reconciliation with pharmacy intervention that identifies gaps in utilization of systemic corticosteroids/bronchodilators after discharge for COPD exacerbations

Intervention Tracking Measures- Case Management Intervention: The plan indicated the following as interventions; however, these are Intervention Tracking Measures which should be used to monitor monthly or quarterly progress of the intervention to coordinate follow up visits with the PCP within 2 weeks of discharge. For both of these intervention tracking measures, the denominator is stated as "The eligible population"; however, it is not clear whether this eligible population is not restricted to members with COPD, as indicated Section E3a, or is restricted to members with COPD, as indicated for the intervention described in E2a, i.e., "Coordinate care transitions by Case Managers for members who experience readmissions for diagnosis of COPD/Asthma".

1. The percentage of members who received follow-up within 30 days of discharge.
2. The percentage of members who received follow-up within 7 days of discharge.

Intervention Tracking Measures- Medication Reconciliation Intervention*:* The plan stated measurement methodology as: "The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge on or between January 1-December 31 of the measurement year and who were dispensed appropriate medications. Intake period: January 1 – December 31 of measurement year. Episode date: Date of service for any acute inpatient discharge during the intake period with a principal diagnosis of COPD. Two rates are reported:

1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 30 days of the event: HEDIS Table PCE-C
2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event: HEDIS Table PCD-D

Results: None reported.

Discussion: Not included.

Improvement shown? No data.

Strengths: The intervention strategies can lead to robust interventions if members with COPD hospitalizations are contacted by case managers prior to discharge from the index hospitalizations for discharge planning and collaborative care plan development.

Opportunities for Improvement:

- The plan should determine which annual performance indicators will be used to evaluate improvement from baseline to final re-measurement years, clearly specify the timeline, initiate new/enhanced interventions after the baseline year, and differentiate annual performance indicators from those measures that will be used to monitor the progress of interventions, i.e., Intervention Tracking Measures (ITMs).

- As interpreted above, it is recommended that the plan monitor the progress of interventions using monthly Intervention Tracking Measures (ITMs) for each intervention; identify stagnating or declining ITM monthly trends; conduct root cause/barrier analysis; and use findings to inform modifications to interventions on an ongoing basis throughout the course of the PIP. Monthly ITM trends could be monitored using run charts. Plan-Do-Study-Act (PDSA) worksheets could be used to plan, monitor and interpret progress of key interventions that represent meaningful tests of change and, with improved ITM rates, used to spread successes to impact a greater proportion of members.

Overall Credibility of Results: Due to the lack of performance indicator data, this PIP cannot be validated.

VI. Strengths, Opportunities for Improvement, and Recommendations

This section lists strengths, opportunities for improvement and recommendations for Medicaid and Medicare Advantage (Platino) plans.

Note: plans that reported data by region/product will appear to have more strengths than plans that reported a single rate for the entire plan.

Medicaid

First Medical

Strengths

HEDIS 2017 Audit

- First Medical was fully compliant with all seven designated Information Systems (IS) categories.

HEDIS 2017 Measures

The following measures are above/better than the 2017 NCQA Medicaid national average.

- Chlamydia Screening in Women (CHL) total: San Juan
- Medication Management for People With Asthma (MMA) ≥ 75% treatment period (total): San Juan, Virtual
- Antidepressant Medication Management (AMM) Acute : Virtual
- Antidepressant Medication Management (AMM) Continuation: Virtual
- Follow-up Care for Children Prescribed ADHD Medication (ADD) Initiation: North, San Juan, Virtual
- Follow-up Care for Children Prescribed ADHD Medication (ADD) Continuation: North, San Juan
- Follow-up After Hospitalization for Mental Illness (FUH) 7 day: North, San Juan
- Follow-up After Hospitalization for Mental Illness (FUH) 30 day: North, San Juan
- Annual Dental Visit (ADV) total: North, San Juan, Virtual

PIPs

- Reviewers found the findings of two PIPs to be valid.

Opportunities for Improvement

HEDIS 2017 Audit

- The following HEDIS 2017 measures are biased: CBP, W15 6+ visits.

HEDIS 2017 Measures

- Of HEDIS 2017 measures compared to the NCQA national average approximately 65 percent (12 of 18) are below the national average[10].

PIPs

- Reviewers found that two PIPs submitted do not meet the criteria to be considered PIPs. They appeared to be information gathering and compliance monitoring projects.

Recommendations

Compliance review

- Compliance reviews were not conducted in 2016-2017. Recommendations made in response to the 2014-2015 compliance review were made in the prior EQR report. Each plan's response to these recommendations can be found in section VII of this report.

HEDIS 2017 Audit

- Address issues leading to biased rates for CBP and W15 6+ visits.

PIPs

- Future PIPs should assess and improve the processes and outcomes of health care provided by an MCO (see CMS Protocol 3).

[10] If any component of a measure was above the NCQA national average the measure was considered to be above the NCQA average for opportunities for improvement.

MMM

Strengths

HEDIS 2017 Measures

The following measures are above/better than the 2017 NCQA Medicaid national average.

- Breast Cancer Screening (BCS): NE, SE
- Chlamydia Screening in Women (CHL) 16-20 years: NE
- Comprehensive Diabetes Care (CDC) Medical Attention for Nephropathy: SE
- Follow-up Care for Children Prescribed ADHD Medication (ADD) Initiation: SE
- Follow-up Care for Children Prescribed ADHD Medication (ADD) Continuation: SE
- Follow-up After Hospitalization for Mental Illness (FUH) 30 days: NE, SE

PIPs

- Reviewers found the findings of all four submitted PIPs to be valid.

Opportunities for Improvement

HEDIS 2017 Audit

- A HEDIS 2017 audit does not appear to have been conducted.

HEDIS 2017

- Of HEDIS 2017 measures compared to the NCQA national average approximately 70 percent (13 of 18) are below the national average[10].

PIPs

- Reviewers found that PIPs either lacked information about improvement in measurement years 1 and 2 or PIPs did not include robust member and provider interventions.

Recommendations

Compliance review

- Compliance reviews were not conducted in 2016-2017. Recommendations made in response to the 2014-2015 compliance review were made in the prior EQR report. Each plan's response to these recommendations can be found in section VII of this report.

HEDIS 2017 Audit

- HEDIS audits should be conducted by NCQA-licensed audit organizations.

PIPs

- Future PIPs should report the progress of the performance indicator(s) for each PIP year.

Molina

Strengths

HEDIS 2017 Measures

The following measures are above/better than the 2017 NCQA Medicaid national average.

- Childhood Immunization Status (CIS) MMR
- Childhood Immunization Status (CIS) Hepatitis A
- Breast Cancer Screening (BCS)
- Medication Management for People With Asthma (MMA) ≥ 75% treatment period (total)
- Comprehensive Diabetes Care (CDC) Medical Attention for Nephropathy
- Antidepressant Medication Management (AMM) Continuation
- Follow-up Care for Children Prescribed ADHD Medication (ADD) Initiation
- Follow-up Care for Children Prescribed ADHD Medication (ADD) Continuation
- Annual Dental Visit (ADV) total

PIPs

- Reviewers found the findings of three of the four PIPs to be valid.

Opportunities for Improvement

HEDIS 2017 Audit

- A complete HEDIS 2017 compliance audit report was not submitted to IPRO.

- The following HEDIS 2017 measures are biased: CDC < 7% control rate.

HEDIS 2017

- Of HEDIS 2017 measures compared to the NCQA national average approximately 60 percent (11 of 18) are below the national average[11].

PIPs

- Reviewers found that results should be interpreted with caution for some PIPs because relevant baseline data was not reported, and there were some inconsistencies in reported data.

Recommendations

Compliance review

- Compliance reviews were not conducted in 2016-2017. Recommendations made in response to the 2014-2015 compliance review were made in the prior EQR report. Each plan's response to these recommendations can be found in section VII of this report.

HEDIS 2017 Audit

- Address issues leading to biased rate for CDC < 7% control.

PIPs

- Future PIPs should include data for all performance measures and take extra care to avoid inconsistences in reported.

Triple-S

Note: Triple-S did not report HEDIS 2017.

Opportunities for improvement

PIPs

- Reviewers found that for 3 of the 5 PIPs there were issues with validation that indicate a bias in the PIP results.
- Reviewers found the following in some or all of the five submitted PIPs:
    - Indicators were not reported on an annual basis and comparisons were not made to a target rate in order to interpret improvement.
    - PIPs lacked a robust set of member and provider interventions.
    - One PIP appeared to be a compliance monitoring project.
    - There was overlap of the intervention period and the baseline period

Recommendations

Note: Triple-S did not report HEDIS 2017.

Compliance review

- Compliance reviews were not conducted in 2016-2017. Recommendations made in response to the 2014-2015 compliance review were made in the prior EQR report. Each plan's response to these recommendations can be found in section VII of this report.

PIPs

- Future PIPs should address the issues affecting PIP validity identified in section V of this report. Future PIPs should also assess and improve the processes and outcomes of health care provided by an MCO (see CMS Protocol 3).

Medicare Advantage (Platino)

Constellation

Strengths

HEDIS 2017 Audit

- Constellation was fully compliant with six of seven designated Information Systems (IS) categories.

[11] If any component of a measure was above the NCQA national average the measure was considered to be above the NCQA average for opportunities for improvement.

HEDIS 2017 Measures

The following measures are above/better than the 2017 NCQA Medicare national average.

- Adult BMI Assessment (ABA): 11761
- Colorectal Cancer Screening (COL): 11761, 11762
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR): 13219
- Statin Therapy for Patients with Cardiovascular Disease (SPC) Received Statin Therapy: 21-75 Years (Male): 11761
- Statin Therapy for Patients with Cardiovascular Disease (SPC) Received Statin Therapy: 40-75 Years (Female): 11761
- Statin Therapy for Patients with Cardiovascular Disease (SPC) Received Statin Therapy: Total: 11761
- Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Testing: 11761
- Comprehensive Diabetes Care (CDC) Medical Attention for Nephropathy: 11761
- Comprehensive Diabetes Care (CDC) BP Control (<140/90 mmHG): 11761
- Statin Therapy for Patients With Diabetes (SPD) Received Statin Therapy: 11761
- Antidepressant Medication Management (AMM) Continuation: 13219
- Follow-up After Hospitalization for Mental Illness (FUH) 7 days: 11761, 11762, 13219
- Follow-up After Hospitalization for Mental Illness (FUH) 30 days: 11761, 11762, 13219
- Annual Monitoring for Patients on Persistent Medications (MPM) ACE inhibitors or ARBs: 11761, 11762, 13219
- Annual Monitoring for Patients on Persistent Medications (MPM) Diuretics: 11761, 11762, 13219
- Annual Monitoring for Patients on Persistent Medications (MPM) Total: 11761, 11762, 13219
- Non-Recommended PSA-Based Screening in Older Men (PSA): 11761
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate1: 11761, 11762
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate2: 11761, 11762
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate3: 11761, 11762
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) total: 11761, 11762
- Use of High-Risk Medications in the Elderly (DAE) one prescription: 11761, 11762, 13219
- Use of High-Risk Medications in the Elderly (DAE) at least two prescriptions: 11761, 11762, 13219
- Adults' Access to Preventive/Ambulatory Health Services (AAP) 20-44 Years: 11761
- Adults' Access to Preventive/Ambulatory Health Services (AAP) 45-64 Years: 11761
- Adults' Access to Preventive/Ambulatory Health Services (AAP) 65+ Years: 11761
- Adults' Access to Preventive/Ambulatory Health Services (AAP) Total: 11761

PIP/QIPs

- Reviewers found that the findings of the submitted QIP to be valid.

Opportunities for Improvement

HEDIS 2017 Audit

- Constellation was not fully compliant with standard IS 4.0 Medical record review processes. The impact on reporting was significant.
- The following HEDIS 2017 measures are biased: CBP.

HEDIS 2017 Measures

- Of reported HEDIS 2017 measures compared to the NCQA national average, 50 percent (10 of 20) are below the national average[12]

Recommendations

Compliance review

- Compliance reviews were not conducted in 2016-2017. Recommendations made in response to the 2014-2015 compliance review were made in the prior EQR report. Each plan's response to these recommendations can be found in section VII of this report.

HEDIS 2017 Audit

- The plan should address the factors that lead to lack of compliance with IS 4.0.

[12] If any component of a measure was above the NCQA national average the measure was considered to be above the NCQA average for opportunities for improvement.

Humana

Strengths

HEDIS 2017 Audit

- Humana was fully compliant with all seven designated Information Systems (IS) categories.

HEDIS 2017 Measures

The following measures are above/better than the 2017 NCQA Medicare national average.

- Colorectal Cancer Screening (COL)
- Annual Monitoring for Patients on Persistent Medications (MPM) ACE inhibitors or ARBs
- Annual Monitoring for Patients on Persistent Medications (MPM) Diuretics
- Annual Monitoring for Patients on Persistent Medications (MPM) Total
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate1
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate2
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate3
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) total
- Use of High-Risk Medications in the Elderly (DAE) one prescription
- Use of High-Risk Medications in the Elderly (DAE) at least two prescriptions

Opportunities for Improvement

HEDIS 2017 Measures

- Of HEDIS 2017 measures compared to the NCQA national average, approximately 85 percent (11 of 13) are below the national average[13].

PIP/QIPs

- The reviewers identified that over the duration of the QIP the population increased by nearly 700% resulting in an inability to determine whether the interventions were affective or not.

Recommendations

Compliance review

- Compliance reviews were not conducted in 2016-2017. Recommendations made in response to the 2014-2015 compliance review were made in the prior EQR report. Each plan's response to these recommendations can be found in section VII of this report.
- Most HEDIS measures reported (11 of 13) fell below the NCQA national average. There is an opportunity to implement targeted interventions to improve performance.

MCS

Strengths

HEDIS 2017 Audit

- MCS was fully compliant with six of seven designated Information Systems (IS) categories.

HEDIS 2017 Measures

The following measures are above/better than the 2017 NCQA Medicare national average.

- Colorectal Cancer Screening (COL): 8882, 13181, 13182
- Controlling High Blood Pressure (CBP) : 8882, 13181, 13182
- Persistence of Beta-Blocker Treatment After a Heart Attack (PBH): 8882
- Osteoporosis Management in Women Who Had a Fracture (OMW): 8882,13181
- Follow-up After Hospitalization for Mental Illness (FUH) 7 day: 8882, 13181
- Follow-up After Hospitalization for Mental Illness (FUH) 30 day: 8882, 13181
- Annual Monitoring for Patients on Persistent Medications (MPM) ACE inhibitors or ARBs: 8882, 13181, 13182
- Annual Monitoring for Patients on Persistent Medications (MPM) Diuretics: 8882, 13181, 13182
- Annual Monitoring for Patients on Persistent Medications (MPM) Total: 8882, 13181, 13182
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate 1: 8882, 13181

[13] If any component of a measure was above the NCQA national average the measure was considered to be above the NCQA average for opportunities for improvement.

- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate 2: 8882, 13181
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate 3: 8882, 13181
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) total: 8882, 13181, 13182
- Use of High-Risk Medications in the Elderly (DAE) one prescription: 8882, 13181, 13182
- Use of High-Risk Medications in the Elderly (DAE) at least two prescriptions: 8882, 13181, 13182

PIP/QIPs

- Reviewers found the findings of both submitted QIPs to be valid.

Opportunities for improvement

HEDIS 2017 Audit

- MCS was not fully compliant with standard IS 7.0 Data Integration. The impact on reporting was significant.

HEDIS 2017 Measures

- Of HEDIS 2017 measures compared to the NCQA national average, approximately 55 percent (7 of 13) are below the national average[14].

PIP/QIPs

- While reviewers identified the findings of both QIPs as valid, they found that the results should be interpreted with caution due to the absence of specific prior year data, low member participation, and difficulty identifying the denominator of a performance measure.

Recommendations

Compliance review

- Compliance reviews were not conducted in 2016-2017. Recommendations made in response to the 2014-2015 compliance review were made in the prior EQR report. Each plan's response to these recommendations can be found in section VII of this report.

HEDIS 2017 Audit

- The plan should address the factors that lead to lack of compliance with IS 7.0.

MMM/PMC Platino

Strengths

HEDIS 2017 Audit

- MMM/PMC was fully compliant with all seven designated Information Systems (IS) categories.

HEDIS 2017 Measures

The following measures are above/better than the 2017 NCQA Medicare national average.

- Colorectal Cancer Screening (COL): 9228, 13246, 12442
- Controlling High Blood Pressure (CBP): 9228, 13246, 12442
- Osteoporosis Management in Women Who Had a Fracture (OMW): 9228, 13246
- Follow-up After Hospitalization for Mental Illness (FUH) 7 day: 9228, 13246
- Follow-up After Hospitalization for Mental Illness (FUH) 30 day: 9228, 13246
- Annual Monitoring for Patients on Persistent Medications (MPM) ACE inhibitors or ARBs: 9228, 12442
- Annual Monitoring for Patients on Persistent Medications (MPM) Diuretics: 9228, 13246, 12442
- Annual Monitoring for Patients on Persistent Medications (MPM) Total: 9228, 13246, 12442
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate 1: 9228, 13246
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate 2: 9228, 13246
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate 3: 9228, 13246
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) total: 9228, 13246, 12442
- Use of High-Risk Medications in the Elderly (DAE) one prescription: 9228, 13246, 12442
- Use of High-Risk Medications in the Elderly (DAE) at least two prescriptions: 9228, 13246

PIP/QIPs

- Reviewers found the findings the QIP to be valid.

[14] If any component of a measure was above the NCQA national average the measure was considered to be above the NCQA average for opportunities for improvement.

Opportunities for improvement

HEDIS 2017 Measures

- Of HEDIS 2017 measures compared to the NCQA national average, approximately 55 percent (7 of 13) are below the national average[15].

PIP/QIPs

- Reviewers reported that the QIP findings should be addressed with caution due to changes in the age cohort reported throughout the duration of the QIP. The performance measure was also not reported resulting in an inability to track intervention success.

Recommendations

Compliance review

- Compliance reviews were not conducted in 2016-2017. Recommendations made in response to the 2014-2015 compliance review were made in the prior EQR report. Each plan's response to these recommendations can be found in section VII of this report.

PIP/QIPs

- Future QIPs should track and report performance measures annually, so that the effectiveness of the interventions can be evaluated.

Triple-S Platino

Strengths

HEDIS 2017 Audit

- Triple-S was fully compliant with all seven designated Information Systems (IS) categories.

HEDIS 2017 Measures

The following measures are above/better than the 2017 NCQA Medicare national average.

- Adult BMI Assessment (ABA): 9271
- Breast Cancer Screening (BCS): 9271
- Colorectal Cancer Screening (COL): 9271, 13348
- Persistence of Beta-Blocker Treatment After a Heart Attack (PBH): 13348
- Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Testing: 9271
- Comprehensive Diabetes Care (CDC) Eye Exam: 9271
- Comprehensive Diabetes Care (CDC) Medical Attention for Nephropathy: 9271
- Comprehensive Diabetes Care (CDC) BP Control (<140/90 mmHG): 9271
- Follow-up After Hospitalization for Mental Illness (FUH) 7 day: 9271, 13348
- Follow-up After Hospitalization for Mental Illness (FUH) 30 day: 9271, 13348
- Annual Monitoring for Patients on Persistent Medications (MPM) ACE inhibitors or ARBs: 9271, 13348
- Annual Monitoring for Patients on Persistent Medications (MPM) Diuretics: 9271, 13348
- Annual Monitoring for Patients on Persistent Medications (MPM) Total: 9271, 13348
- Non-Recommended PSA-Based Screening in Older Men (PSA): 9271
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate 1: 9271, 13348
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate 2: 9271, 13348
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) rate 3: 9271, 13348
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) total: 9271, 13348
- Use of High-Risk Medications in the Elderly (DAE) one prescription: 9271, 13348
- Use of High-Risk Medications in the Elderly (DAE) at least two prescriptions: 13348
- Adults' Access to Preventive/Ambulatory Health Services (AAP) 20-44 Years: 9271
- Adults' Access to Preventive/Ambulatory Health Services (AAP) 45-64 Years: 9271
- Adults' Access to Preventive/Ambulatory Health Services (AAP) 65+ Years: 9271
- Adults' Access to Preventive/Ambulatory Health Services (AAP) total Years: 9271

[15] If any component of a measure was above the NCQA national average the measure was considered to be above the NCQA average for opportunities for improvement.

Opportunities for Improvement

HEDIS 2017 Measures

- Of HEDIS 2017 measures compared to the NCQA national average, approximately 65 percent (17 of 26) are below the national average[16].

PIP/QIPs

- Due to a lack of performance indicator this QIP could not be validated.

Recommendations

Compliance review

- Compliance reviews were not conducted in 2016-2017. Recommendations made in response to the 2014-2015 compliance review were made in the prior EQR report. Each plan's response to these recommendations can be found in section VII of this report.

PIP/QIPs

- Future QIPs should track and report performance measures annually, so that the effectiveness of the interventions can be evaluated.

[16] If any component of a measure was above the NCQA national average the measure was considered to be above the NCQA average for opportunities for improvement.

VII. Plan Response to Prior Recommendations

The purpose of this section is to assess the degree to which each MCO has addressed the opportunities for improvement made by IPRO in the prior EQR technical report (contract years 2014-2015).

MCOs responding from last EQR technical report are: Medicaid: First Medical, Molina, MMM/PMC, Triple-S; Medicare: Constellation, Humana, MMM Platino, PMC Platino, MCS Platino, Triple-S Platino

IPRO sent MCO's the following request on 4/4/29.

In order to comply with federal regulations, IPRO must include in the current External Quality Review (EQR) Technical Report (review period 2016-2017), an assessment of the degree to which each MCO has addressed the recommendations for quality improvement made by IPRO in the 2016 EQR Technical Report (review period 2015) that was finalized in December 2016. Please complete the attached table, describing current and proposed interventions that address each recommendation, as well as explain areas that you do not feel are within its ability to improve.

IPRO will include your response to the 2016 recommendations in the current report. Please use the attached form to document your response.

For **each** recommendation, please respond to the following questions:

- What has the MCO done/planned to address each recommendation?
- When and how was this accomplished? For future actions, when and how will they be accomplished?
- What is the expected outcome of the actions that were taken or will be taken?
- What is the MCO's process for monitoring the actions to determine their effectiveness?

The following are unedited responses from the MCOs.

Medicaid

First Medical

Table 34: First Medical's Response to Recommendations

IPRO Recommendation	MCO Response
▪ **Finding:** Each Company has five (5) days to notify ASES about the referrals made to the US Attorney's Field Office and HHS-OIG. Non- Compliance: Not addressed in Policies and Procedures. ▪ **IPRO Recommendation:** Examine the regulatory requirements designated with minimal and non-compliance and take corrective action to achieve compliance.	**Initial Plan of Action-** Update of the Full Investigations Policy and Procedure to reflect referenced information. **How was this accomplished?** The Full Investigations Policy and Procedure and the Medicaid Integrity Compliance Program was updated and submitted to IPRO with the CAP Response. ***Please refer to section 5.4 of the Full Investigations Policy and Procedure updated on 12/2016.*** FMHP also included an updated version of the Full Investigations Policy and Procedure which was updated on 04/19/2017. In addition, ***please refer to pages the highlighted section in pages 36-40 of the Medicaid Integrity Compliance Program, specifically page 39 highlighted in green.*** **Outcome and Monitoring-** FMHP maintains a log of all cases referred. Per normative letter from PRHIA dated 03/17/2019, Full Investigation results must be referred to the PRHIA within two (2) business days, as of the date the investigation was completed. PRHIA will discuss the case, if necessary with the OIG. ***Please refer to Normative Letter 17-0214 Enmendada.*** However, if requested by the PRHIA, FMHP must refer the case to the OIG within the applicable timeframe. **Future Actions/Plans-** No further actions are required. FMHP will continue to assure that compliance with regulatory timeframes is met.

▪ **Finding:** Each Company has five (5) days to notify ASES about any adverse or negative action that the MCO has taken on provider application (upon initial application or application renewal) or actions which limit the ability of providers to participate in the program. Non-Compliance: Documentation could not be found that	**Initial Plan of Action–** Applicable Providers Department Policies and Compliance Department Policies will be reviewed to determine where referenced information will be included. **How was this accomplished?** After careful review FMHP included this information in the Medicaid Integrity Compliance Program. ***Please refer to the Highlighted section (Yellow) in page 26.*** The updated Medicaid Integrity Compliance Program was submitted to IPRO with the CAP Response. In addition, the Notification to PRHIA of Suspended and Debarred Network Providers P&P reflects that ASES will be notified within twenty-four (24) hours upon final determination. ***Please refer to Notification to PRHIA of Suspended and Debarred Network Providers P&P*** **Outcome and Monitoring-** On a quarterly basis, FMHP submits the Provider Suspensions and Terminations report to the PRHIA. This Report includes the providers name, specialty, NPI, reason(s) for the action taken, and the effective date of suspension or termination. If FMHP has not taken action against providers, this information will also be documented in the

Molina

Table 35: Molina's Response to Recommendations

IPRO Recommendation	MCO Response
▪ Examine the regulatory requirements designated not fully met and take corrective action to achieve compliance, especially for those with repeated deficiencies.	***I. Enrollee Rights & Protections*** IPRO's recommendations were geared towards revising certain policies and procedures (P&Ps) to meet full compliance. **Initial Plan of Action –** Alignment of P&Ps to applicable regulatory requirements as recommended by IPRO. **How was this accomplished?** Reviewed applicable regulatory requirements related to IPRO's recommendations and amended impacted policies (2) to include regulatory requirements. Impacted business unit leads were educated on regulatory requirements and applicable procedures. Revised P&Ps were submitted to ASES for final review and approval in January of 2017. **Outcome and Monitoring –** Full compliance with the regulatory requirements achieved by the revision and modification of P&Ps. Upon receipt of new regulatory requirements (by means of contractual amendments, legislation, health oversight agencies' regulations, and/or new contracts – Vital), a gap analysis is performed to evaluate changes and process impacts. If warranted, P&Ps are revised and impacted business units are trained accordingly. Compliance Department may audit to ensure adequate implementation of new requirements. **Future Actions/Plans – Gap Analysis for Vital:** P&Ps were reviewed during Readiness Review in September – October 2018 to ensure alignment and compliance with Vital Program requirements, particularly if said requirements were new under the program. ***II. QAPI – Structure & Operations*** IPRO's commentaries relate to regulatory provisions regarding procedures for disenrollment, where the recommendations consist of including required regulatory language in the Enrollee Handbook. Molina was unable to make the recommended changes as under both the previous and current model the content for the Enrollee Handbook is solely created by ASES.

IPRO Recommendation	MCO Response
	III. Grievance System – see below.
▪ Review all policies, procedures and enrollee forms to ensure that all state and federal regulations regarding grievances are addressed.	**Initial Plan of Action –** Alignment of P&Ps and enrollee forms (Notice of Action) to applicable regulatory requirements. **How was this accomplished? –** An internal Corrective Action Plan was sought from the impacted business units following IPRO's Compliance Review report and findings. Business owners were given target dates for completion to ensure timely implementation. Corrective actions included the review/revision of P&Ps related to appeals & grievances and notices regarding provision of services, as well revising the Notice of Action form (now Adverse Benefit Determination) that goes out to enrollees. A&G personnel were re-trained on regulatory requirements and applicable procedures. **Outcome and Monitoring –** **1)** Corrective Action Plan was presented to ASES as part of an audit of Article 14 – Grievance System performed on June 27, 2016. CAP was presented on August 28, 2016 and closed by ASES on December 5, 2016. **2)** Internal audits have been conducted by Compliance **3)** Continuous review/revision of P&Ps due to new contractual/regulatory requirements since 2016 **Future Actions/Plans –** P&Ps and enrollee forms (currently Notice of Adverse Benefit Determination) were reviewed during Readiness Review in September – October 2018 to ensure alignment and compliance with Vital Program requirements. Modifications to P&Ps and enrollee forms were made as the Vital Program contract delineates new requirements (TATs) for A&G and approved by ASES prior to November 1, 2018.

MMM and PMC

Table 36: MMM/PMC's Response to Recommendations

IPRO Recommendation	MCO Response
▪ This requirement is addressed in the Provider Directory. Non-English (or non-Spanish) languages spoken by contracted providers are not indicated in this directory. Recommendation for Multi & PMC. • The non-Spanish languages should be indicated in the provider directory.	• **Initial Plan of Action –** Procedures are carried out so that non-Spanish languages are included in the directory. • **How was this accomplished?** - Non-Spanish languages were included in the Directory by June 2018 as a result of new programming to attend this matter. • **Outcome and Monitoring** – The directory is constantly verified for compliance of contract terms by the Provider Network Optimization Unit. • **Future Actions/Plans** – Daily operational processes monitor compliance of directory requirements (under the responsibility of the PNO Unit)
▪ This requirement is partially addressed in the Enrollee Handbook and on the Plan's webpage. Assistance from the Plan in the filing process is only specified for members filing a complaint. For members filing a grievance, the member is advised that "Your physician, a relative or a person authorized by you, can file the Grievance on your behalf". There is no mention of assistance in the appeals process. However, it is noted that the Enrollee Handbook is provided by ASES and the plan has no authority to change its content. Recommendation for Multi & PMC. • PMC should insure that the toll-free numbers that the enrollee can use to file a grievance or an appeal by phone are included in the member handbook created by ASES.	• **Initial Plan of Action** – Review the Enrollee`s Handbook and send to ASES so that the phone number available to beneficiaries to file a grievance or an appeal by phone was corrected and included in the handbook. The MCO does not have the authorization by the regulator to correct this document. • **How was this accomplished?** –It was addressed with ASES and the information was included in the latest version of the Enrollee Handbook. • **Outcome and Monitoring** – The Enrollee Handbook was verified and the information is accurate and accessible to beneficiaries in various platforms. • **Future Actions/Plans** – Monitoring of the Enrollee Handbook and its requirements is an on-going process.

IPRO Recommendation	MCO Response
• This requirement is addressed in the Provider Guidelines (pages 15-16), the Enrollee Handbook (pages 25-26 and 30), and in the Advance Directive informational posters. • The policies do not clarify differences between institution-wide conscience objections and those that may be raised by individual physicians; • Identify the state legal authority permitting such objection; describe the range of medical conditions or procedures affected by the conscience objection. • Policies do not state that the MCO will not discriminate against an individual based on whether or not the individual has executed an advance directive. • It is noted that the Enrollee Handbook is provided by ASES and the plan has no authority to change its content. • Furthermore, members are instructed to contact ASES for all issues regarding Advanced Directives. Recommendation for Multi & PMC. • MMM should assure that the policies clarify differences between institution-wide conscience objections and those that may be raised by individual physicians; • Identify the state legal authority permitting such objection; describe the range of medical conditions or procedures affected by the conscience objection. The policies should state that the MCO will not discriminate against an individual based on whether or not the individual has executed an advance directive.	• Initial Plan of Action – The Medicaid Compliance Department updated the policies and procedures to incorporate the difference between conscience objections from Providers classified as Institution versus Individuals or Physicians. The Puerto Rico legal authority (ASES) was adopted as the entity to track, analyze and provide response of objections. All the medical conditions and procedures impacted were described as part of the steps considered to handle the cases. In addition, specific non-discriminatory language against Individual based on whether or not the Individual has executed an advance directive was implemented. The information was shared with MMM and PMC Operations and approved by ASES and the defined internal bodies. • How was this accomplished? – This recommendation was completed during an ad-hoc policies and procedures review once the Medicaid Compliance Department became aware of the findings on; June, 2017. • Outcome and Monitoring – At present, these elements are part of Department's annual work plans, including but not limiting to the Annual Risk Assessment, Auditing and Monitoring Work Plan and Compliance Work Plan. Several evaluations are completed through the year confirming that the elements are in control. No additional concerns have been identified. • Future Actions/Plans – a) Complete the next annual review of policies and procedures scheduled for 2nd Quarter of 2019. b) Submit updated documentation to ASES, as part of the required MCO's document submission and approval process on the 3rd and 4th Quarters of 2019. c) Perform additional assessments to the areas reviewed and recommended with this exercise by December 31, 2019. d) Keep the Medicaid Compliance Department and Operations updated with any new regulatory change implemented with MCOs (if applicable).

IPRO Recommendation	MCO Response
• This requirement is addressed in GA 001, Template Notice of Action. • Adverse Letter PMC/MMM: o Standard Notification of Adverse Determination of Medical Coverage (PMC/MMMG-PAU- LET-264-031915-S), PHGHP-009 Prior Authorization/Exception on • Coverage Determination Notification Denial Letter • UM File Review – • 3 of the 10 files reviewed included the member's right to request a State fair hearing. • 5 of the 10 files reviewed were denials on non-inpatient services which did not include the member's right to request a State fair hearing. • 2 of the 10 files reviewed were inpatient retrospective reviews, for which the member has no liability, so this requirement was not applicable. • Recommendation for PMC PMC should insure that the member's right to a State fair hearing is included in the denial letter.	• Initial Plan of Action – Review and modify denial letter template to incorporate Member's rights to a state fair hearing, according to the federal requirement language. • How was this accomplished? - After revision of template, internal protocol related to Member's communications was followed. The Public Relations department approved final format and it was implemented in the operation. • Outcome and Monitoring – Internal audit include criteria related to denial letter template requirements. • Future Actions/Plans – Assure alignment with the Medicaid Compliance Department in order to guarantee that processes comply with federal requirements.

IPRO Recommendation	MCO Response
• This requirement is addressed in GA 001 page 9, • Adverse Letter PMC/MMM: • Standard Notification of Adverse Determination of Medical Coverage (PMCG- PAU-LET-264-031915-S), • PHGHP-009 Prior Authorization/Exception • Coverage Determination Notification Denial Letter and GHP Provider Service Agreement- Sample. • UM File Review • 3 of the 10 files reviewed included the member's right to have benefits continue pending resolution of the appeal. • 5 of the 10 files reviewed were denials on non-inpatient services which did not include the member's right to request to have benefits continue pending resolution of the appeal. • 2 of the 10 files reviewed were inpatient retrospective reviews, for which the member has no liability, so this requirement was not applicable. Recommendation for PMC • PMC should insure that the denial letter include the enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.	• Initial Plan of Action – Review and modify denial letter template to incorporate recommended languages: - The Enrollee's rights to have benefits continue pending resolution of the appeal. - How to request that benefits be continued. - Circumstances under which the Enrollee may be required to pay the costs of these services. • How was this accomplished? - After revision of template, internal protocol related to Member's communications was followed. The Public Relations Department approved final format and it was implemented in the operation. • Outcome and Monitoring – Internal audit include criteria related to denial letter template requirements. • Future Actions/Plans – Assure alignment with the Medicaid Compliance Department in order to guarantee that processes comply with federal requirements.

IPRO Recommendation	MCO Response
• This requirement is addressed in GA 001 and the Enrollee Handbook. • Appeal File Review • None of the 10 appeals files reviewed provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person. The "Standard Notification of Denial of Health Coverage" doesn't allow for submitting the appeal "in person". It specifically says that for standard appeal, it must be submitted "in writing by mail or fax", and for the expedited appeal, it they must either contact "by phone or fax". Recommendation for PMC • The plan should update the "Standard Notification of Denial of Health Coverage" to provide for submitting the appeal in person.	• Initial Plan of Action – Review and modify denial letter template to specify Member's rights to submit an appeal in person, according to the federal requirement language. • How was this accomplished? - After revision of template, internal protocol related to Member's communications was followed. The Public Relations Department approved final format and was implemented in the operation. • Outcome and Monitoring – Internal audit include criteria related to denial letter template requirements. • Future Actions/Plans – Assure alignment with the Medicaid Compliance Department in order to guarantee that processes comply with federal requirements.

IPRO Recommendation	MCO Response
• Consideration of the needs of enrollees in not addressed in HSCM-62. • The Advisory Board includes enrollee representation. Meeting minutes demonstrate participation of enrollees in the committee. Recommendation for PMC • The plan should add a description of how enrollee needs are considered when adopting/developing guidelines to the policy. • The QAPI Program Description includes goals, details strategies, such as PIPs, performance measurements, member and provider satisfaction surveys, ER Quality Initiative Program and the Quality Incentive Program. The description lists involved personnel by title. • Committees are not presented in the description but are described in policies as noted below. • The QAPI Work Plan lists 9 activities. The Work Plan should address all activities in the Program Description, and include objectives, responsible staff, timeframe, planned actions, expected outcomes, benchmark and goals, evaluation of goals/activities, barrier analysis, completion date and next steps. • The following policies were provided: • HSQM-013 QAPI Program for the Government Health Plan (notes that the QAPI program description and annual program evaluation are presented, discussed and	• Initial Plan of Action – Adopt IPRO's recommendation by incorporating description into Clinical Practice Guidelines policy, and other operational policies. • How was this accomplished? Language pertaining to considering Enrollee needs when adopting/developing clinical guidelines was added to the stated policy as of 2017. • Outcome and Monitoring – The Advisory Board and the Quality Improvement Committee (QIC) serve as the oversight forums to monitor compliance with this activity. These forums take place at least on a quarterly basis. • Future Actions/Plans – Assess by the end of 2019 if other type of open forums like the Advisory Board should also be available to gather Enrollee's input corresponding to health care services delivery needs and expectations, and if so, incorporate them to the work-plan. • Initial Plan of Action –Adopt IPRO's recommendation by incorporating respective language into the QAPI Program Description. • How was this accomplished? – During the first quarter of 2017, the QAPI Program Description was updated to include further references to the Quality Improvement Committee (QIC) and to the Advisory Board that describe their purpose, structure and accountabilities, moreover their relationship (QIC is a higher level of oversight). • Outcome and Monitoring – No barriers were encountered; both committees have been ongoing, at least on a quarterly basis, and complying with expected targets. • Future Actions/Plans – Include by the end of July 2019 in the Quality Improvement Committee and in the Advisory Board policies additional language that describes their relationship and a related flowchart.

IPRO Recommendation	MCO Response
approved by the Quality Improvement Committee). • HSQM-019 Quality Improvement Committee (QIC) describes the membership, responsibilities and procedures of the QIC. • The Advisory Board includes members and providers as members, and is informed of quality improvement activity results. The QIC provides oversight of the QAPI program and activities. • PMC provided meeting agendas, packages and minutes for the Advisory Board meetings in Q2 (6/23/15), Q3 (9/10/15), and Q4 (12/3/15). The documents provided evidence of attendance by members and providers, and showed discussion and decision-making by the membership. Each meeting included an open forum component. • PMC provided meeting agendas, packages and minutes for the QIC meetings held 9/23/15 and 1/18/16. The overall QI program was presented to the committee as well as details regarding several activities. The 1/18 minutes noted that meetings would occur monthly in Q1 2016 and then move to a quarterly schedule.	

IPRO Recommendation	MCO Response
Recommendation for PMC • The plan should include a description of the quality committee structure in the QAPI Program Description, as well as, a description and/or organizational chart showing the reporting relationship between the Advisory Board, QIC, and other committees. • The Work Plan should address all activities in the Program Description, and include objectives, responsible staff, timeframe, planned actions, expected outcomes, benchmark and goals, evaluation of goals/activities, barrier analysis, completion date and next steps.	• Initial Plan of Action – Adopt IPRO's recommendation by enhancing the documentation of the QAPI work-plan. • How was this accomplished? – During the first quarter of 2017, several documents used to monitor the overall QAPI work-plan at the quality improvement activity level were consolidated into an Excel layout, which does address all of the QAPI activities, objectives, responsible staff, timeframe, planned actions, expected outcomes, benchmark and goals, evaluation of goals/activities, barrier analysis, completion date, next steps, among others. • Outcome and Monitoring – The updated work-plan layout has been used since 2017, monitoring of QAPI indicators are ongoing, discussed during the QIC at least quarterly and fully evaluated on an annual basis. • Future Actions/Plans – At least on an annual basis, assess if enhancements to the work-plan layout and/or to the technical tools used to monitor the quality improvement activities are required to identify possible areas of improvement proactively.

IPRO Recommendation	MCO Response
• Includes Credentialing and Recredentialing file review results (1) Addressed in policy and procedure titled "Organizational Provider Credentialing" (2) Addressed in policy and procedure titled "Practitioner Initial Credentialing". Addressed in policy and procedure titled "Re-credentialing" page 3. • Credentialing and Recredentialing file review • Of the 5 Initial Credentialing files 1 Specialist file did not contain whether he had hospital privileges or his educational history and 1 Specialist file was incomplete. • Of the 5 Recertification files reviewed, 1 PCP recertification was not done in a timely manner. Initial certification was 2010. All other areas of the file review were compliant.	• Initial Plan of Action - The Credentialing Program enables MSO of Puerto Rico to ensure that all participating and Providers are continuously in compliance with the Centers for Medicare and Medicaid Services (CMS) requirements, MSO of Puerto Rico policies and procedures, and any other applicable regulatory or accrediting entity's requirements and/or standards. The process of peer review is established, when considering contracting with a Practitioner or Provider who does not meet established credentialing standards such as negative findings in the NPDB report, before a final determination is made. • How was this accomplished? -Provider's signed application is used as an attestation for hospital privileges, work history and all verifications. The Credentialing Staff review the Work History in the application form, to confirm is completed and accurate. If an application is incomplete the Credentialing Staff contact the Provider in order to correct erroneous or missing information. A Curriculum is acceptable and must include the beginning and ending month and year for each position. The Credentialing Staff contact Practitioners for verbal clarification of any gap greater than (6) six months, and document the discussion in the credentialing file. • Outcome and Monitoring – Conducts audits for timeliness and compliance with credentialing standards, and implement corrective actions if necessary. The Credentialing Department audits Provider's file based on CMS regulations and company policy and procedures. MMM also conducts annual audits that are in effect for twelve (12) months or longer. Future Actions/Plans – To maintain under compliance our credentialing process, MSO maintains updated documentation of credentialing policies and procedures according with state and federal requirements. Also, several assessments are completed through the year to ensure a correct management of the credentialing cycle.

IPRO Recommendation	MCO Response
• Partially addressed in Provider's Guidelines, 2.7, Disenrollment, page 11. However, the guidelines do not contain language regarding disenrollment because of an adverse change in health status, utilization of medical services, or diminished mental capacity. Recommendation for PMC • PMC should assure that all contract language is included in the Provider Guidelines.	• Initial Plan of Action – Review of the Guideline. Include the disenrollment language in the Provider language and submit to ASES for review and approval. • How was this accomplished? – The language in the Provider Guidelines was included on December 13, 2016. • Outcome and Monitoring – Every year the Provider Guidelines is updated to include all operational areas for review of their parts and submit to ASES for review and approval. The information complies with the contract language requirement in the Provider Guidelines 2016. • Future Actions/Plans- Update the Provider Guidelines at least annually or more often if required by ASES.
• Partially addressed in Beneficiaries Manual, Disenrollment, page 13 but does not address the recipient's representative as submitting an oral or written request. Documentation for (1) (i) and (ii) can be found in Beneficiaries Manual, Disenrollment, page 13. Recommendation for PMC •PMC should assure that all contract language is included in the Provider Guidelines.	• Initial Plan of Action – Update Beneficiaries' Manual to incorporate the missing information about Recipient's Representative when submitting an oral or written request and submission to ASES for the final review and approval. • How was this accomplished? This was accomplished during the document submission required by ASES to all the MCOs of Puerto Rico. • Outcome and Monitoring – No additional concerns were identified after the final review and approval of ASES. However, the element is part of the annual documentation review and analysis that is performed by MMM. • Future Actions/Plans – Maintain the recommendation and ensure the adoption of any new requirement defined with the Manual. Re-submit the information to ASES if applicable**.**

Triple-S

Table 37: Triple-S' Response to Recommendations

IPRO Recommendation	MCO Response
Evaluate overall HEDIS performance against the Quality Compass™[17] benchmarks, assess three-year trends for measures, assess region-specific performance and develop and implement targeted interventions to improve performance.	**Initial Plan of Action –** Increase the percentage compare to previous year and achieved the national rate. **How was this accomplished?** • Providers quality audits • Providers orientation about preventive services and HEDIS Measures • Physician incentive to high performance providers • Corrective Action Plans to low performance providers • Members letter (Gaps In care) **Outcome and Monitoring –** 2016 National Rate not available. An increase was obtained in the metrics reporting at least during two consecutive years. The monitoring was performed through medical record reviews. **Future Actions/Plans**

[17] Quality Compass is a registered trademark of the National Committee for Quality Assurance (NCQA).

IPRO Recommendation	MCO Response

Measures	Sub-Measure	2014 Metro North	2014 West	2015 Metro North	2015 West	2016 Metro North	2016 West	Delta Metro North	Delta West
ABA		17.03%	15.57%	NR	NR	60.10%	63.99%	252.91%	310.98%
WCC	BMI	6.08%	27.01%	NR	NR	44.77%	35.28%	636.35%	30.62%
	Counseling for nutrition	11.68%	22.38%	NR	NR	49.39%	28.22%	322.86%	26.09%
	Counseling for Physical activity	7.06%	19.95%	NR	NR	43.31%	26.76%	513.46%	34.14%
CIS	DTaP	30.90%	50.36%	NR	NR	71.53%	74.21%	131.49%	47.36%
	IPV	38.93%	57.18%	NR	NR	84.43%	84.67%	116.88%	48.08%
	MMR	74.94%	73.97%	NR	NR	85.64%	90.27%	14.28%	22.04%
	Hib	53.28%	68.61%	NR	NR	87.35%	88.08%	63.95%	28.38%
	Hep B	30.17%	49.64%	NR	NR	60.58%	62.53%	100.80%	25.97%
	VZV	69.10%	72.51%	NR	NR	82.00%	86.13%	18.67%	18.78%
	PNC	27.01%	45.50%	NR	NR	59.61%	66.42%	120.70%	45.98%
	Hep A	60.34%	75.67%	NR	NR	86.62%	86.86%	43.55%	14.79%
	Rotavirus	25.06%	47.20%	NR	NR	56.45%	58.64%	125.26%	24.24%
	Flu	6.81%	15.09%	NR	NR	11.44%	12.17%	67.99%	-19.35%
BCS		61.61%	57.66%	66.09%	64.19%	70.47%	67.29%	14.38%	16.70%
CCS		46.72%	47.69%	NR	NR	54.74%	51.09%	17.17%	7.13%
CHL		35.62%	46.55%	44.36%	51.29%	NR	NR	24.54%	10.18%
ASM		66.79%	56.20%	91.18%	87.68%	NR	NR	36.52%	56.01%
MMA						40.07%	32.55%		
CBP		13.63%	13.14%	NR	NR	44.04%	51.82%	223.11%	294.37%
CDC	Hemoglobin A1c (HbA1c) Testing	68.25%	48.72%	NR	NR	72.08%	64.23%	5.61%	31.83%
	A1c poor control	91.24%	93.80%	NR	NR	62.59%	72.45%	-31.40%	-22.76%
	A1c control	5.84%	4.93%	NR	NR	30.84%	20.62%	428.08%	318.26%
	Eye Exam	21.35%	19.89%	NR	NR	29.20%	26.82%	36.77%	34.84%
	Nephropathy	77.92%	70.80%	NR	NR	91.97%	88.32%	18.03%	24.75%
	BP Control	12.96%	10.58%	NR	NR	45.99%	51.09%	254.86%	382.89%
AMM	84 days			NR	NR	36.30%	43.33%		
	180 days			NR	NR	19.26%	24.22%		
ADD	Initiation phase			NR	NR	30.22%	38.59%		
	Continuation and maintenance			NR	NR	64.37%	53.59%		
FUH	Within 7 days			NR	NR	62.89%	71.71%		
	Wuthun 30 days			NR	NR	81.56%	85.12%		
URI		78.59%	84.35%	NR	NR	76.07%	79.95%	-3.21%	-5.22%
AAP	20-44y/o	63.16%	59.17%	63.16%	59.81%	64.57%	59.85%	2.23%	1.14%
	45-64y/o	77.90%	76.50%	77.90%	77.04%	79.43%	77.28%	1.96%	1.01%
	65+y/o	80.12%	80.52%	80.12%	81.39%	81.59%	80.85%	1.84%	0.41%
CAP	12-24 months	83.91%	83.33%	84.89%	85.60%	89.01%	88.27%	6.08%	5.93%
	25 months- 6 y/o	77.16%	77.23%	77.71%	78.76%	83.11%	83.23%	7.71%	7.77%
	7-11y/o	72.20%	77.44%	82.92%	81.96%	87.47%	87.25%	21.15%	12.67%
	12-19y/o	65.17%	67.73%	75.19%	73.30%	80.08%	78.57%	22.87%	16.00%
ADV		57.20%	57.28%	59.23%	58.04%	58.52%	58.80%	2.31%	2.65%
PPC	Timeliness	76.64%	71.78%	NR	NR	83.70%	79.81%	9.21%	11.19%
	Postpartum care	19.46%	18.25%	NR	NR	30.17%	24.09%	55.04%	32.00%
FPC	<21	3.41%	4.14%	NR	NR	2.43%	1.95%	-28.74%	-52.90%
	21-40%	2.19%	3.41%	NR	NR	2.68%	2.68%	22.37%	-21.41%
	41-60%	9.25%	12.65%	NR	NR	7.30%	8.03%	-21.08%	-36.52%
	61-80%	21.17%	40.63%	NR	NR	19.22%	38.44%	-9.21%	-5.39%
	81+%	63.99%	39.17%	NR	NR	68.37%	48.91%	6.84%	24.87%
W15 6+visits		1.70%	4.38%	NR	NR	9.73%	3.89%	472.35%	-11.19%
AWC		16.30%	12.41%	NR	NR	29.68%	14.60%	82.09%	17.65%
AMB				NR	NR	75.01%	99.84%		

NR: Not Reportable

Ensure that performance improvement projects are methodologically sound	**PIP 2016 Fistula- Health care services for PSG patients with Renal Conditions under Special Coverage receiving services with PR Renal Clinic and fistula as treatment option.**

IPRO Recommendation	MCO Response
and measurement indicators and results are clearly defined. PIPs should be evaluated on an ongoing basis. Interventions should be modified with updated results.	**Initial Plan of Action –** The project included all chronic renal patients under special coverage in the Medicaid population including those with special health care needs- renal stage IV and V receiving services with PR Renal. The PIP objective was evaluation of chronic renal patients by a multidisciplinary team and refer chronic renal patient's candidates to fistula to a vascular surgeon. PIP benefits for participant members • More access to multidisciplinary services. • Treatment option with lower risk of infection. • Continuity of services in patients with Fistula. **How was this accomplished?** Performing the following strategies: • Educations efforts • Telephone calls by nurses to provide follow-up to members. • Access to multidisciplinary services. • Fistula as treatment option for the patients. **Outcome and Monitoring –** **Multidisciplinary services offered, 2016**

Services	2016 Q1	2016 Q2	2016 Q3	2016 Q4
Internist	28	35	6	0
Nephrologist	86	87	103	62
Nutritionist	46	59	64	30
Social Worker	29	2	17	8

Frequency of treatment modalities selected by patients, 2016

Indicators	2016 Q1	2016 Q2	2016 Q3	2016 Q4
Total Patients	56	68	81	60
Education offered	18	32	40	8
Patients oriented about Fistula	14	22	28	8
Patients with mapping	7	8	6	7
Patients referred to Vascular Surgeon	7	3	10	2

IPRO Recommendation	MCO Response

Patients that accept Fistula as treatment	4	6	4	2
Other treatment options	0	5	7	2
Peritoneal Dialysis	0	0	1	1
Arteriovenous Graft	0	1	1	0
Kidney Transplant	0	4	5	1
Patients evaluated by a multidisciplinary team	55	61	81	60

On a quarterly basis and based upon the results obtained, the project team continued with the interventions if there was improvement or w re-evaluated the interventions if there was no improvement. The results were presented in the Quality Committee on quarterly basis.

Future Actions/Plans - Continue the project by looking for new strategies to the barriers identified.

PIP 2016 Reverse Co-location-Establish and comply with the Reverse Co-location Model in compliance with Reverse Collocation Guidelines as established by ASES

Initial Plan of Action- All Behavioral Health Facilities (BHF) should comply with 100% compliance of ASES reverse co-location guidelines

How was this accomplished? – This goal was achieved by ensuring that contracted facilities complied with the obligation of placing a general physician in all the BHF's.

Outcome and Monitoring – Achieved 100%; this outcome was achieved by the quarterly audits performed at BHF's

Future Actions/Plans – For the future year this project was enhanced by adding reverse co-location number of services

PIP 2016 Co-location-Improve the communication between behavioral health providers and PCP's in co-location model

Initial Plan of Action- Improve the communication between the Behavioral Health Practitioners and Primary Care Physicians in the Co-Location Model from an established baseline of 1.5 %

How was this accomplished? – Provider education on the model and the established documentation and codes used to account for established communications between the selected providers

Outcome and Monitoring – Achieved by an increase from the baseline from 1.5% to 20 .6%, which is an increment of 19.1%; this outcome was achieved by the quarterly audits in regard to the case discussion quantities.

Future Actions/Plans – For the future year this project was enhanced by adding an electronic codification system to be used by providers.

PIP 2016 Behavioral Health -Adherence of Antidepressant Medication Management (AMM)

Initial Plan of Action – Improve the percentage of the antidepressant adherence for patients diagnosed with Major Depressive Disorder using HEDIS like methodology

How was this accomplished? – Patients discharged from total psychiatric hospitalization were called by the pharmacy department to ensure post discharge compliance with antidepressant medications.

IPRO Recommendation	MCO Response
	Outcome and Monitoring – Non-Achieved**;** this outcome was established by reaching the 50th percentile of 49.7 and APS reached 39.6; the monitoring of this metric was performed quarterly. Most prominent barrier for non-achieving the expected result was the actual contact of post discharge patients including, change in phone number or out of service numbers limiting the achievement in this metric. **Future Actions/Plans –** Continue project. **PIP 2016 EPSDT -Well Child Visits** **Initial Plan of Action-** The project incorporated as indicator the HEDIS measure named Well Child Visit and represented the percentage of members who were identify as percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. This indicator allowed Triple-S to measure change in enrollees' health status. The change in health status were measure based on the following indicators among participants: • Clinical Analytics Department developed an impact population assessment between the ages of 0 to 15-month-old without preventive visits required. • Health Education and Preventive Service unit developed a strategies plan and initiative to impact members and providers about the importance of EPSDT and preventive services, well child visits appointment coordination and the proper follow up. • Continue education efforts about EPSDT requirements and CPT codification to primary medical groups and PCPs. • Clinical indicators: Well child visits completed. The project goal was at least a 3% increase annually. **How was this accomplished?** • Educations efforts directed to the enrollees such as immunizations and developmental topics • Coordination of educational workshops and Health Fairs with the inclusion of well child visit • Implementation of Pediatric Preventive Center for provision of well child visits • Telephone calls by Demand management staff to reminder well child visit and/or coordination of appointment • Include Well Child Visit related topics in the Continued Medical Education activities. • It was implemented the first Pediatric Care Center model service in the West Region focus on ESPDT bright futures recommendations and Puerto Rico preventive care guidelines with a multidisciplinary team, including Outreach Unit, Pediatric preventive specialist, laboratories and dental services under the same infrastructure. **Outcome and Monitoring:** **Outcome-** For the study period, calendar year 2016, demonstrate a significantly increase in the preventive visits of children compare to calendar year 2015.

Study Period	Q1	Q2	Q3
2016	45.80%	51.33%	54.17%
2015	6.82%	25.04 %	26.4%

IPRO Recommendation	MCO Response
	The Preventive Visits Educational Activities performed to Members in the Primary Medical Groups for the period from January to December 2016 was a total of 330 educational activities impacting 3,428 insured pediatric population, compare to 2015 calendar year a total of 166 educational activities were carried out impacting 1,410 insured pediatric population. It demonstrates a 50% of increment for the educational activities performed in the study period compare with 2015 study period. The impact of insure population for 2016 was 41% increase compare to 2015 study period. The topics covered were immunizations and developmental. **Monitoring -** Each quarter, the results were calculated using the same methodology for data collection and analysis to allow comparability. Upon conclusion of the data analysis plan, the project team members interpreted the results and determine the success of the project and follow-up activities. The preventive care unit developed operational reports to present in the Quality Committee on quarterly basis about the outreach, preventive services coordination and educational efforts outcomes. **Future Actions/Plans -** Continue the project and the initiatives. The Quality Clinical Executive team evaluate and determine if there is sustained improvement, If the actual strategies generate the quarterly outcomes expected by Triple -S will continue with the strategies or may recommend new improvement strategies. The Quality Clinical Committee will: • Evaluate the rate for the indicators- clinical/utilization. • Determine if there is improvement by comparing baseline to repeated results on a quarterly/annually basis • Incorporate recommendations, re-evaluate improvement strategies and implement collection/reporting processes steps. The preventive care unit developed operational reports to present in the Quality Committee on quarterly basis about the outreach, preventive services coordination and educational efforts outcomes. **Future Actions/Plans** Continue the project and the initiatives. The Quality Clinical Executive team evaluate and determine if there is sustained improvement, If the actual strategies generate the quarterly outcomes expected by Triple -S will continue with the strategies or may recommend new improvement strategies. The Quality Clinical Committee will: • Evaluate the rate for the indicators- clinical/utilization. • Determine if there is improvement by comparing baseline to repeated results on a quarterly/annually basis • Incorporate recommendations, re-evaluate improvement strategies and implement collection/reporting processes steps.

Medicare Advantage (Platino)

Constellation

Table 38: Constellation's Response to Recommendations

<table>
<tr><th>IPRO Recommendation</th><th>MCO Response</th></tr>
<tr><td>▪ Evaluate HEDIS performance against the Quality Compass™[18] benchmarks for cardiovascular, diabetes and medication management. Develop and implement targeted interventions to improve performance.</td><td>
Initial Plan of Action –
To develop a Model of Care Monitoring Tool that include the benchmarks.
To run quarterly reports to identify non-compliance members
How was this accomplished?
Developed target interventions to improve the performance

Make available the gaps in care reports to PMG's and PCP's thru a Web tool
Wellness clinics were held on PCP offices, Nursing Homes, "Egidas" and Health fairs.
Incentive to providers that use the CPT Level II codes
Developed education bulletins and distributed to members through the Wellness Clinics, Sales Agents and providers representatives
Participation of MCO staff in alliance with providers in a radio program where different health issues are discussed
Sent Letters to members with the Individual Care Plan (ICP) that include the gaps in care
Medical appointments coordination for labs and Health Risk Assessment in home
Developed a product for services at home called "Genesis at Home" (H3054-004)
Since CY 2018 the eye glasses are included in all three products
For CY 2019 - included in two of the products (Genesis at Home and Genesis Prime) unlimited non-emergency transportation
Social workers from the Outreach program that visited the members with socioeconomic issues that may affected their adherence to treatment

Outcome and Monitoring –
For cardiovascular condition the results showed improvement in the rate of adherence for statin therapy and persistent of Beta-Blocker Treatment after Heart Attack but remains under the national benchmark for Medicare for the other measures. It may affected by the Hurricanes that impacted Puerto Rico during 2017.
<table>
<tr><th>Cardiovascular Conditions</th><th colspan="3">Constellation Health Rates</th><th colspan="3">Benchmarks</th></tr>
<tr><td></td><td>2015</td><td>2016</td><td>2017</td><td>2015</td><td>2016</td><td>2017</td></tr>
<tr><td>Controlling High Blood Pressure (cbp)</td><td>20.4%</td><td>BR</td><td>18.3%</td><td>67.9%</td><td>69.6%</td><td>70.9%</td></tr>
<tr><td>Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)</td><td>N/A</td><td>81.0%</td><td>84.5%</td><td>90.9%</td><td>90.1%</td><td>90.0%</td></tr>
</table>
</td></tr>
</table>

[18] Quality Compass is a registered trademark of the National Committee for Quality Assurance (NCQA).

IPRO Recommendation	MCO Response

Statin Therapy for Patients With Cardiovascular Disease (spc)						
Received Statin Therapy - Total	N/A	87.8%	81.5%	N/A	77.3%	79.0%
Statin Adherence 80% - Total	N/A	59.5%	68.6%	N/A	75.5%	76.3%

For Diabetes Management Constellation Health there are improvements in HbA1c testing, Hb1Ac poor control, Hb1Ac <8%, medical attention for nephropathy, blood control pressure and statin adherence. The rate for eye exam and received statin therapy decrease. The Hb1aC testing, medical attention for nephropathy, blood pressure control and received statin therapy are over the national average for Medicare.

Diabetes	Constellation Health Rates			Benchmarks		
Diabetes Comprehensive Care	2015	2016	2017	2015	2016	2017
Hemoglobin A1c (HbA1c) Testing	91.0%	93.9%	94.7%	93.2%	93.5%	93.7%
HbA1c Poor Control (>9.0%)	83.0%	52.3%	37.0%	27.4%	26.3%	25.4%
HbA1c Control (<8.0%)	17.0%	33.1%	48.2%	62.7%	62.9%	64.4%
Eye Exam (Retinal) Performed	68.9%	65.7%	60.8%	68.8%	70.4%	71.9%
Medical Attention for Nephropathy	99.0%	99.0%	98.5%	95.5%	95.6%	95.7%
Blood Pressure Control (<140/90 mm Hg)	30.2%	81.5%	82.0%	61.9%	63.9%	67.4%
Statin Therapy for Patients With Diabetes (SPD)						
Received Statin Therapy	71.0%	74.8%	73.3%	N/A	70.7%	72.3%
Statin Adherence 80%	N/A	60.4%	65.4%	N/A	75.3%	74.0%

Regarding the medication management there are improvements in MRP and High-risk Medications rates in the elderly but the rates remains under national average.

Medication Management	Constellation Health Rates			Benchmarks		
	2015	2016	2017	2015	2016	2017
Medication Reconciliation Post-Discharge (MRP)	6.8%	11.4%	20.7%	27.2%	46.1%	47.5%
Use of High-Risk Medications in the Elderly (DAE)						
One Prescription	30.0%	31.9%	29.9%	9.6%	11.2%	14.1%
At Least Two Prescriptions	7.8%	14.4%	13.2%	1.2%	1.7%	9.3%

IPRO Recommendation	MCO Response
	Future Actions/Plans – • Personal medical appointment coordination where a Constellation Health Representative identify the provider necessity and coordinate all the services including the transportation with the providers. • Make available to members a website with centralized data for all the personal health care records, plan data and physicians history • Continued with all above initiatives
▪ Measures of particular focus for improvement should include Controlling High Blood Pressure, Diabetes (HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%) and Blood Pressure Control) and Use of High-Risk Medications in the Elderly.	**Initial Plan of Action –** To improve the performance metrics **How was this accomplished?** Target interventions to improve performance: • Make available the reports to PMG's and PCP's thru a Web tool • Wellness clinics were held on PCP offices, Nursing Homes, "Egidas" and Health fairs. • Incentive to providers that use the CPT Level II codes • Developed education bulletins and distributed to members through the Wellness Clinics, Sales Agents and providers representatives • Participation of MCO staff in alliance with providers in a radio program where different health issues are discussed • Sent Letters to members with the Individual Care Plan (ICP) and follow-up thru to care management • Medical appointments coordination for labs • Developed a product for services at home called "Genesis at Home" (H3054-004) • For CY 2019 - included in two of the products (Genesis at Home and Genesis Prime) unlimited non-emergency transportation • Include in the plan benefits all diabetes supplies • Include in the plan benefits the blood pressure monitor if necessary **Outcome and Monitoring –** Quarterly reports were done to identify non-compliance members. See the evaluation in the first item. **Future Actions/Plans –** • Personal medical appointment coordination where a Constellation Health Representative identify the provider necessity and coordinate with the providers all the services including the transportation. • Make available to members a website with centralized data for all the personal health care records, plan data and physicians history • Continued with all above initiative

IPRO Recommendation	MCO Response
▪ Review the plan's QI Work Plan and annual evaluation of the impact and effectiveness of the plan's quality assessment and performance improvement program to ensure compliance with state and federal regulations. Revise and update the QI Work Plan as appropriate.	**Initial Plan of Action –** • To activate the Quality Steering Committee • To do an annual program evaluation of the Quality Improvement Program **How was this accomplished? –** Since December 2016 the Quality Steering Committee was activated. Since December 5, 2016 a total of 16 meetings were held. The members include the Medical Director, Clinical Affairs and Credentialing Director, Pharmacy Director, Data Analytics, Quality and Star Rating Manager, Capitation Manager and Compliance Manager. The Quality Steering Committee is responsible for the following: • Evaluation of the Quality Improvement Program using the performance metrics of the Model of Care • Evaluation of the Quality Improvement Project (QIP) • Identify areas to develop new QIP • Identify areas of improvement • Monitoring the MOC • Utilization Monitoring • Developed Quality Policies and Procedures **Outcome and Monitoring –** • Evaluation of the Quality Improvement Project 2015-2017 • Developed and Implemented a new QIP for CY 2018 – Reducing Emergency Department Visits • Continued in CY 2018 with the QIP - Plan All Causes Re-admissions but as a CCIP with emphasis in prolonged stays • Developed the Model of Care for 2018 – The Model of Care was approved by CMS for three years (2018-2020) • 2017 Annual Evaluation • Developed and implemented a MOC Corrective Action Plan in response of 2017 CMS audit. • All policies and procedures regarding the Quality Program were reviewed at least annually. **Future Actions/Plans –** • 2018 Annual Evaluation – Expected completion date – July 2019 • The regulation regarding Quality Improvement Projects (QIP) and Chronic Care Improvements Program (CCIP) change. Beginning 1/1/2019 the MAO's are no longer required to conduct QIPs. However, Constellation Health continue with the initiative of the CY 2018 QIP, "Reducing the Emergency Department Visits"
▪ Review grievance and appeal forms and communications with enrollees to ensure that information provided is consistent with state and federal regulations.	**Initial Plan of Action –** Denial Letter was updated accordingly**.** Also the Grievances and Appeals forms are revised annually and updated whenever necessary to ensure that local and federal regulations are addressed. **How was this accomplished?** Automated template was updated. An annual review of Policies and Procedures and attachments. **Outcome and Monitoring –** Notification letter is part of the ongoing monitoring process within the Clinical Affairs Department and audited by the Compliance Department quarterly. **Future Actions/Plans –** None

IPRO Recommendation	MCO Response
▪ Review policies and procedures related to access to ensure that all state and federal regulations are addressed	**Initial Plan of Action –** Policies and procedures are revised annually and updated whenever necessary to ensure that local and federal regulations are addressed. **How was this accomplished? –** Annual review process of Policies and Procedures. **Outcome and Monitoring –** Compliance Department provides oversight and monitoring of this process. **Future Actions/Plans –** None

Humana

Table 39: Humana's Response to Recommendations

IPRO Recommendation	MCO Response

Evaluate HEDIS performance against the Quality Compass™[19] benchmarks for measures in need of improvement including prevention and screening, diabetes care, behavioral health (Antidepressant Medication Management), medication management and Initiation and Engagement of AOD Treatment. Develop and implement targeted interventions to improve performance.	**Initial Plan of Action –**
	Humana Puerto Rico HEDIS measures performance is evaluated annually using the following approach; a three year trend, rate changes between years and NCQA Quality Compass for Reporting Year using the Average, 10th, 50th and 90th percentile; including market ranking for each measure.
	How was this accomplished?
	• HEDIS trends are evaluated by key stakeholders at Humana Corporate and the markets for the purpose of recommending goals for HEDIS each year. After review of HEDIS trends, historical goals, and accreditation requirements (where applicable), goals are recommended for HEDIS.
	• Annual results are presented at the Corporate Quality Improvement Committee (Humana aggregate data) and at the market level for recommendations.
	• Corporate team oversees HEDIS performance for the Medicare Advantage population and manages improvement initiatives to drive member compliance for HEDIS metrics. The team also leads clinical interconnectedness and collaboration across multiple business areas and the markets in an effort to maximize the HEDIS performance opportunity.
	• At the market level several departments work together to develop and implement initiatives focused on improving HEDIS measures including; Stars Maximization Team, Wellness Program, Provider Engagement Team, Care Management Program, Network and Contracting team among others.
	• For HEDIS measures related to Behavioral Health, annual results are shared with APS; Humana's MBHO and initiatives are worked in collaboration to improve those measures. APS have representation in the market Quality Improvement Committee.
	• Several initiatives are developed during the year including but not limited to:
	  ○ Telephonic Member Outreach programs
	  ○ Face to Face events to close gaps in care
	  ○ Vaccination events

[19] Quality Compass is a registered trademark of the National Committee for Quality Assurance (NCQA).

IPRO Recommendation	MCO Response
	○ Visits to targeted providers and medical groups ○ Member incentives for completion of preventive services ○ Mailing of educational material ○ Coordination of services at member's home ○ Educational activities for members ○ Educational activities for providers **Outcome and Monitoring –** Humana uses several avenues to monitor HEDIS measures progress included but not limited to: • No visit in the past 12 months • HEDIS Detail Pivot list members who are eligible for each measure and weather they pass the measure or not • Membership roster by provider list members assigned to each provider • HEDIS Summary summarized view of data as HEDIS detail • ER visit report • Current Admission Report • Rx Quality Opportunities includes all Part D measures at member level • Patient Experience Report show results of member experience and satisfaction at the provider level • Predictive Model displays data by measure including goals and expected performance Many of these reports are available for providers while other are used internally to monitor progress. Humana conduct several meetings at Corporate and market level to discuss results and strategies to improve measures. **Future Actions/Plans –** • Continue to monitor HEDIS rate trends throughout the claims run out period and HEDIS chart retrieval season. • Continue to optimize our member outreach strategy, leveraging member level data (response and behavior) to help direct the next best action to take in effort to assist members in getting the care that they need. • Continue to re-define our strategy for the industry lagging measures (OMW, BCS, EYE and RA). While our performance rates continue to improve, we are not improving for these measures as fast as the industry. • Continue to develop and grow Enterprise partnerships to maximize Quality performance. • Expand efforts to view care needs end to end, beyond Stars gap closure, to ensure best in class care delivery.
Ensure that performance improvement projects are methodologically sound and measurement indicators and results are clearly defined. PIPs should be evaluated on an ongoing basis.	**Initial Plan of Action –** Humana conducts QIPs for Medicare members to measure performance, apply interventions to improve performance, evaluate performance and conduct periodic follow-up to measure effectiveness of interventions and outcomes. The projects are selected based on study topics determined by CMS. In addition, analysis is done to determine high volume and high risk conditions prevalent in this population. The projects have the potential for significant impact on health outcomes. The status and results of QIPs are reported using the CMS-required tools and processes. These studies are maintained for 3 years. In addition, CMS utilizes the 'Plan/Do/Study/Act approach to quality improvement. Annual trainings are provided by CMS to provide guidance for the QIP requirements. Initial submission of the project consists of only the "Plan" section of the "Plan, Do, Study and Act" template. Following implementation of the

IPRO Recommendation	MCO Response
	"Plan", annual updates are made to the studies. The Quality Operations Compliance & Accreditation (QOCA) Clinical Studies Team (CST) must prepare to attest that they have ongoing QIPs as CMS has the authority to request information periodically on the status and results of ongoing projects. **How was this accomplished? –** Humana Clinical Studies Team (CST) is responsible for the oversight of QIPs and work with the markets in the implementation of the projects. Historically, CMS has required annual updates and submission of the studies under the requirements outlined in 42 CFR §422.152 of the Medicare Managed Care Manual. The CST works with a number of partners and stakeholders at Corporate and market level to update and maintain the studies each year. **Outcome and Monitoring –** The QIPs include the following components: • Measurement of performance • System interventions, including establishment or alteration of practice guidelines • Improving performance • Systematic and periodic follow-up on the effect of the interventions Performance is assessed under health plans using quality indicators that are: • Based on systematic ongoing collection and analysis of valid and reliable data • Objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research • Capable of measuring outcomes such as changes in health status, functional status and enrollee satisfaction, or valid proxies or those outcomes • Able to achieve demonstrable improvement **Future Actions/Plans –** On October 10, 2018 CMS provided new guidance on Quality Improvement Projects requirements for the CY 2019 Medicare Part C and D Final Rule (CMS-4182-F), published in the Federal Register on April 16, 2018. CMS modified the Quality Improvement Program requirements for MAOs in 42 C.F.R. § 422.152(a)(3) and (d).1 establishing that effective January 1, 2019, MAOs are no longer required to conduct QIPs. MAOs should close out all QIPs by the end of CY 2018 and document final results, best practices, and lessons learned in their final QIP Annual Update and complete their final QIP attestation in HPMS by December 31, 2018.
Examine the regulatory requirements designated not fully met and take corrective action to achieve compliance, especially for those with repeated deficiencies.	**Initial Plan of Action – N/A, no item was identified as non-compliance.** **How was this accomplished? –** **Outcome and Monitoring –** **Future Actions/Plans –**

MMM Platino

Table 40: MMM Platino's Response to Recommendations

IPRO Recommendation	MCO Response
Examine the regulatory requirements designated not fully met and take corrective action to achieve compliance, especially for those with repeated deficiencies.	**Initial Plan of Action –** The Medicaid Compliance Department has established a new process that involves MMM MH Operations, to assess in an ongoing basis all the applicable state and federal requirements. The process involves a review of all the existing and new standards against the current documentation. Including but not limiting; policies and standard operating procedures. Once a discrepancy is detected, the information is referred in writing to the applicable area with the recommended actions. Also, a timeline to address. Several discussions during implementation are allowed until the requirement is satisfied. **Outcome and Monitoring –** No additional concerns at this point. However, is always a challenge to be in top with all the changes in the healthcare industry To this end, the great business relation with the state regulator is important and helpful. **Future Actions/Plans –** Continue with the ongoing assessments considering the exploration of regulatory websites and available information to be up to date and mitigate any risk. Keep the operation aware at any time.

PMC Platino

Table 41: PMC Platino's Response to Recommendations

IPRO Recommendation	MCO Response
Examine the regulatory requirements designated not fully met and take corrective action to achieve compliance, especially for those with repeated deficiencies.	**Initial Plan of Action –** The Medicaid Compliance Department has established a new process that involves MMM MH Operations, to assess in an ongoing basis all the applicable state and federal requirements. The process involves a review of all the existing and new standards against the current documentation. Including but not limiting; policies and standard operating procedures. Once a discrepancy is detected, the information is referred in writing to the applicable area with the recommended actions. Also, a timeline to address. Several discussions during implementation are allowed until the requirement is satisfied. **Outcome and Monitoring –** No additional concerns at this point. However, is always a challenge to be in top with all the changes in the healthcare industry To this end, the great business relation with the state regulator is important and helpful. **Future Actions/Plans –** Continue with the ongoing assessments considering the exploration of regulatory websites and available information to be up to date and mitigate any risk. Keep the operation aware at any time.

MCS Platino

Table 42: MCS Platino's Response to Recommendations

IPRO Recommendation	MCO Response
▪ The Contractor shall include in the Enrollee Handbook instructions on how to report Fraud and Abuse and the protections for whistleblowers. It is recommended that the plan add the requirement to its policies and procedures.	**Initial Plan of Action –** MCS included in the website information for enrollees regarding whistleblower protections. Also, MCS amended its Procedure PD-MA-004 "Enrollee Rights & Protections" to include this information. **How was this accomplished?** Effective August 10, 2017**,** MCS included required information in company website and amended policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program" to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.
▪ At a minimum, the Contractor shall include in each report, with respect to individual investigations of Fraud, Abuse, or Waste: All communication between the Contractor and the provider about the complaint. The plan should add these requirements to its policies and procedures.	**Initial Plan of Action –** MCS amended its Procedure CA-COMP-005 "Self Reporting of Potential or Actual FWA, Misconduct or Noncompliance issues to Government Authorities and/or Law Enforcement Agencies" to include required information which was already included in the files sent to ASES. **How was this accomplished? –** Effective February 1, 2017**,** MCS amended required policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program", to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.
▪ At a minimum, the Contractor shall include in each report, with respect to individual investigations of Fraud, Abuse, or Waste: Date of the complaint. The plan should add these requirements to its policies and procedures.	**Initial Plan of Action –** MCS amended its Procedure CA-COMP-005 "Self Reporting of Potential or Actual FWA, Misconduct or Noncompliance issues to Government Authorities and/or Law Enforcement Agencies" to include required information which was already included in the files sent to ASES. **How was this accomplished? –** Effective February 1, 2017, MCS amended required policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program", to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.

IPRO Recommendation	MCO Response
▪ The Contractor shall also include in the report a summary (not specific to an individual case) of: a. Investigative activities, corrective actions, prevention efforts, and results; and b. Trending and analysis of utilization management and provider payment management.	**Initial Plan of Action –** MCS amended its Procedure CA-COMP-005 "Self Reporting of Potential or Actual FWA, Misconduct or Noncompliance issues to Government Authorities and/or Law Enforcement Agencies" to include required information which was already included in the files sent to ASES. **How was this accomplished? –** Effective February 1, 2017, MCS amended required policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program", to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.
▪ The Contractor shall report to ASES, within (1) one business day of obtaining knowledge with respect to the identity of any provider or other person who, in violation of 42 CFR 438.610 (a) and (b), is debarred, suspended, or otherwise prohibited from participating in procurement activities. ASES shall promptly notify the Secretary of HHS of the noncompliance, as required by 42 CFR 438.610(c).	**Initial Plan of Action –** MCS amended its Procedure CA-COMP-005 "Self Reporting of Potential or Actual FWA, Misconduct or Noncompliance issues to Government Authorities and/or Law Enforcement Agencies" to include required information. **How was this accomplished? –** Effective February 1, 2017, MCS amended required policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program", to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.
▪ Each Company has five (5) days to notify ASES about the referrals made to the US Attorney's Field Office and HHS-OIG. The plan should add the five day requirement to its policy.	**Initial Plan of Action –** MCS amended its Procedure CA-COMP-005 "Self Reporting of Potential or Actual FWA, Misconduct or Noncompliance issues to Government Authorities and/or Law Enforcement Agencies" to include required information. **How was this accomplished? –** Effective February 1, 2017, MCS amended required policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program", to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.

IPRO Recommendation	MCO Response
▪ Each company must submit to the Compliance Office a certification signed by the Compliance Director and the President or CEO indicating that all full investigations were made in accordance with 42 CFR 455.15.	**Initial Plan of Action –** MCS amended its Procedure CA-COMP-005 "Self Reporting of Potential or Actual FWA, Misconduct or Noncompliance issues to Government Authorities and/or Law Enforcement Agencies" to include required information. **How was this accomplished? –** Effective February 1, 2017, MCS amended required policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program", to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.
▪ Each Company has five (5) days to notify ASES about any adverse or negative action that the MCO has taken on provider application (upon initial application or application renewal) or actions which limit the ability of providers to participate in the program.	**Initial Plan of Action –** MCS amended its Procedure CA-COMP-005 "Self Reporting of Potential or Actual FWA, Misconduct or Noncompliance issues to Government Authorities and/or Law Enforcement Agencies" to include this requirement. **How was this accomplished? –** Effective February 1, 2017, MCS amended required policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program", to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.
▪ Each Company should develop and implement procedures to report to HHS-OIG and ASES within 20 working days any criminal conviction disclosures made during the MCO credentialing process. Copy of the policies should be submitted to ASES Compliance Office. The plan should add the requirement, in its entirety, to a policy or procedure.	**Initial Plan of Action –** MCS amended its Procedure CA-COMP-005 "Self Reporting of Potential or Actual FWA, Misconduct or Noncompliance issues to Government Authorities and/or Law Enforcement Agencies" to include required information. **How was this accomplished? –** Effective February 1, 2017, MCS amended required policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program", to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.

IPRO Recommendation	MCO Response
▪ Each Company must submit to the Compliance Office a certification signed by the Compliance Director and the President or CEO stating compliance with 42 CFR 455.106. This requirement is not addressed in the plan's policies or procedures.	**Initial Plan of Action –** MCS amended its Procedure CA-COMP-005 "Self Reporting of Potential or Actual FWA, Misconduct or Noncompliance issues to Government Authorities and/or Law Enforcement Agencies" to include required information. **How was this accomplished? –** Effective February 1, 2017, MCS amended required policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program", to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.
▪ Each Company must comply with requirement in 42 CFR 455.20 and must document in a quarterly report compliance with regulation. The plan should add the requirement, in its entirety, to a policy or procedure.	**Initial Plan of Action –** MCS amended its Procedure CA-FWA-004 "Investigation management Process of Suspected Fraud, Waste and Abuse/Integrity Program" to include required information. **How was this accomplished? –** Effective February 1, 2017, MCS amended required policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program", to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.
▪ The organization will select a sample to perform independent reviews to verify that recipient's services billed by providers (as well as encounters under capitated environment) were indeed rendered. This review will be performed through confirmations to beneficiaries. The submitted documentation does not reference a specific methodology for sampling members to confirm member receipt of services from providers.	**Initial Plan of Action –** MCS amended its Procedure CA-FW-004 "Investigation Management Process of Suspected Fraud, Waste and Abuse/Integrity Program" to include required information. **How was this accomplished? –** Effective February 1, 2017, MCS amended required policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program", to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.

IPRO Recommendation	MCO Response
▪ The PIP must include withholding of payment processes and procedures to enforce above guideline.	**Initial Plan of Action –** MCS amended its Procedure PR-CRED-012 "Re-credentialing application" to reinforce the above guideline. **How was this accomplished? –** Effective February 1, 2017, MCS amended required policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program", to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.
▪ Notification to Inspector General. (1) The organization must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information. (2) The organization must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program. The plan should add the requirement, in its entirety, to its policies and ▪ procedures.	**Initial Plan of Action –** MCS amended its Procedure CA-COMP-005 "Self Reporting of Potential or Actual FWA, Misconduct or Noncompliance issues to Government Authorities and/or Law Enforcement Agencies" to include required information. **How was this accomplished? –** Effective February 1, 2017, MCS amended required policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program", to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.
▪ Cause for disenrollment. The following are cause for disenrollment: (i) The enrollee moves out of the MCO's service area. (ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks. (iii) The enrollee needs related services (for example	**Initial Plan of Action –** MCS amended its procedure "OP-ENCL-027 MA & MAPD Voluntary Disenrollment and Procedures" to include the required language regarding a change in health status, utilization of medical services and diminished mental capacity. **How was this accomplished? –** Effective December 6, 2016, MCS amended required policies and procedures. **Outcome and Monitoring –** Policies and Procedures are revised annually or less frequently when needed by the Regulatory and Operational Compliance (ROC) Unit of the MCS Compliance Department, as included in Procedure CA-COMP-001 "Development and Administration of MCS Policies and Procedures, Code of Conduct and Compliance Program", to assure compliance with regulatory changes, changes in contractual requirements with regulatory agencies, the results of auditing, monitoring or investigations and/or changes in the Company's operations. **Future Actions/Plans –** Not applicable. MCS completed actions required.

IPRO Recommendation	MCO Response
a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk. (iv) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs. Disenrollment and Policy OP-ENCL-027 MA, MAPD Voluntary Disenrollment and Procedures should be updated to include the required language.	
• Measures in need of improvement for MCS include Use of Spirometry Testing for COPD:	MCS operational areas have dedicated resources toward analyzing and improving specific HEDIS measures, such as: Use of Spirometry Testing, which were identified as below the MA National Mean. MCS has conducted extensive QI analysis and implemented QI initiatives to improve these HEDIS measures. MCS has also identified barriers influencing the expected outcomes, and subsequently, identified initiatives to increase future rates for these measures. Common influences for several measures are addressed through a singular initiative or by multiple initiatives. Operational areas/departments, such as, the MCS Education and Wellness Department, Pharmacy Department, Quality Analytics Department, Provider Network Education Department, Premium Management Department, among others, have worked together to implement practical ways to address the unique health needs of the specific MA-SNP population. In addition to strategic planning, when designing initiatives, MCS took into consideration the beneficiary and provider preferences. **Initial Plan of Action and How Was This Accomplished:** **1. Preventive Reminders - Education and Wellness Department** **a)** Since Calendar Year 2016, the MCS Health Education and Wellness Department has sent out (via U.S. Mail) ongoing preventive reminders (to beneficiaries), to promote awareness amongst targeted enrollees and

IPRO Recommendation	MCO Response
	their providers, toward increasing the spirometry testing as the confirmatory diagnostic test for enrollees with new diagnosis of COPD. This information sent to beneficiaries is both informational and also used to encourage use of Spirometry Testing for COPD to improve this particular HEDIS Measure. This initiative was conducted in both CY2016 and 2017. **b)** In CY2016, and 2017, MCS used Health Informatics Reports to identify enrollees who were not in compliance with screening tests or evaluations related to specific HEDIS/Stars Measures. These reports are known as Gaps In Care Reports. Using these Gaps In Care Reports, the MCS Health Education and Wellness Department sent a preventive reminder letter twice a year, to enrollees who were identified as non-compliant with the Spirometry Test, Additionally, in 2017, MCS sent a preventive reminder postcard to any identified member with a new COPD diagnosis, to inform and also promote, the use of the spirometry test. Spirometry testing is like the gold standard for diagnosing and assessing COPD. This test is often underused, so MCS information sent to members' addresses how a spirometer is a device used to measure how effectively and how quickly the lungs can be emptied, and why this test is an important diagnostic. **2. Health Risk Annual Assessment - Premium Management Department** **a)** The MCS Premium Management Department conducted numerous interventions addressing Gaps In Care with MCS providers and non-compliant enrollees. The targeted enrollees were those enrollees who were not compliant with the Screening Test for Spirometry to confirm new/active COPD diagnosis. **b)** New for Calendar Year (CY) 2015, MCS launched the eCHRA (electronic Comprehensive Health Risk Assessment), which is an electronic version of the annual health risk assessment tool. This version included a new section entitled, "Preventive Care". This section was based on Clinical Practice Guidelines, which is a decision-support tool for the plan and practitioner. This can be used as a guide for the Physician to gather documentation related to the Screening test for Spirometry to confirm a new/active COPD diagnosis. **c)** In CY 2017 and CY 2018, MCS implemented a project to perform the Spirometry Test and the results were shared with both the enrollees and PCPs to contribute to the quality and continuity of care of the beneficiary. **3. Education to Participant Providers Medical Staff about measure compliance- Provider Network Education Dept.** **a)** In CY 2017 and CY 2018, MCS offered education to our providers and their medical staff about the importance of compliance with the Use of Spirometry Testing in the Assessment and Diagnosis of COPD measure, explaining how Spirometry testing is like the gold standard for diagnosing and assessing COPD. This test is often underused, so MCS education to the providers and their staff addresses how a spirometer is a device used to measure how effectively and how quickly the lungs can be emptied, and why this test is an important diagnostic.

IPRO Recommendation	MCO Response
	4. Gaps In Care Reports to Providers – Stars Analytics Department **a)** The Stars Analytics Department developed a series of reports, called: "The Gaps in Care Report." This Report is produced and distributed every two weeks, to share with the providers the compliance and non-compliant status of their empaneled enrollees who are eligible for the SPR HEDIS measure, to monitor proper diagnosis for member with COPD. This report is shared with the PCPs, and it is available electronically 24/7 in the MCS Provider Portal "Provinet". The Gaps in Care Reports were initially implemented in 2015; however, the process is continually improved on an ongoing basis annually. **Outcome and Monitoring of the HEDIS Measure** **1.** MCS examined the yearly improvement in the SPR HEDIS measure to assess the impact of our initiatives. The expected outcome is to improve the compliance of the SPR HEDIS Measure through the Use of Spirometry Testing in the Assessment and Diagnosis of COPD. The rate is monitored and compared with the SNP National Mean, as the SNP National Mean is considered the benchmark for this measure. The baseline will be HEDIS 2015 rates. **2.** The success of the initiative was also measured by the practitioner and beneficiary with the proposed interventions. The overall strategies and initiatives were monitored throughout the measurement year to improve the compliance rate. **3.** In CY 2016, a Preventive reminder letter, to the identified non-compliant population, was sent in July 2016 to 28,537 SNP enrollees and again in November 2016 to 67,776 SNP enrollees. In CY 2017, personalized preventive reminders were sent to a total of 6,116 SNP enrollees. **4.** Providers and medical staff were educated by MCS staff concerning the Use of Spirometry Testing in the Assessment and Diagnosis of COPD. The SPR HEDIS Measure and strategies to comply were also discussed with each provider office. For CY 2016, there were a total of 4,460 participants; for CY 2017, there were a total of 5,120 participants, and for CY 2018, there were a total of 5,898 participants who received this provider/medical staff education. **5.** The overall results reflect that the rates for this SPR HEDIS Measure increased within each active SNP- PBP. HEDIS 2018 showed the highest rate since HEDIS 2015. **a)** In HEDIS 2015 the result was 0.68% in the SNP 002 group. This year was considered to be the baseline. Amongst the following years, MCS had incrementally been improving the compliance rate for this measure. **b)** PBP 002, was the PBP with the most membership and has been in existence for the most years. Unfortunately, even with our initiatives, we experienced low rates in this measure from HEDIS 2014 through HEDIS 2017. In these years, our rates were lower than the SNP National Mean; however, there

IPRO Recommendation	MCO Response
	was a significant increase for 2018, reflecting a significant improvement. Often the full effects of initiatives take a few iterations and cycles before improvement occurs. For PBP 017: In HEDIS 2017 the rate was lower than the SNP National Mean; however, we saw a significant increase in the HEDIS 2018 rate, with an increase higher than the SNP national mean. HEDIS 2018 reflects Calendar Year 2017 data, so it would appear that the effects of the initiatives we began in 2016, began to show in the data from CY 2017, which is reported as HEDIS 2018. **c)** Other SNP PBP's active in or after 2015 were closed however interventions were in place for SNP enrollees with the criteria. 1. For PBP 009: for this PBP between HEDIS 2014 and HEDIS 2016 the rates were lower than the SNP National Mean. The highest rate was in HEDIS 2015. HEDIS 2016, was the last season of this PBP. 2. For PBP 010: for this PBP between HEDIS 2014 and HEDIS 2016 the rates were lower than the SNP National Mean. The highest rate was in HEDIS 2015, the last year of this PBP. 3. For PBP 019: the rate was lower that the MA National Mean and lower when compared with the results of the other PBP's from HEDIS 2016 and HEDIS 2017. However, this was the only season of this PBP. **6.** The educational activities are supported by different components in order to validate and monitor the learning of the participants such as: attendee's registry, feedback evaluations, satisfaction surveys, physician's education interventions scorecards. **7.** In addition, the Premium Management staff meets with each project staff monthly to discuss the results of the reports and establish Corrective Action Plans, if applicable. **8.** From CY 2017 Q3 and early 2018, significant challenges related to the devastating Hurricane Maria aftermath contributed to significant barriers. This required additional coordination, community resource coordination, and support and best efforts, to complete proposed tasks and achieve the set goals. **Future Actions/Plans** **1.** MCS will continue the interventions with enrollees and providers to increase the outcomes and monitor the measure's improvement and Compliance Rate. MCS will continue with the integration of information technology to support QI initiatives. **2.** MCS will continue the identification of possible emerging barriers and the adoption of best practices to continue to improve the SPR HEDIS Measure.
• Measures in need of improvement for MCS include Pharmacotherapy Management of COPD Exacerbation	**Initial Plan of Action and How Was This Accomplished:** **1. Pharmacy Quality initiatives- Pharmacy Department** **a.** MCS has ongoing Pharmacy Quality Projects to monitor proper treatment of enrollees with COPD Exacerbation. This project consists of a target diagnosis, or medical condition, which is required, in order to have adequate treatment. To improve this indicator in CY 2016 and 2017, the MCS Pharmacy Department

IPRO Recommendation	MCO Response
	performed interventions addressing targeted enrollees and providers. Targeted enrollees included beneficiaries with COPD that did not receive bronchodilators within 30 days of the event, or Corticosteroids within 14 days of the event. **b.** In CY2016 and CY2017, MCS sent out letters to encourage compliance with identified members, eligible for the measure, but not complying with the use of Corticosteroids or Bronchodilators. Letters were sent to their Physicians who were managing the condition. MCS identified the population with this diagnosis, and measured the therapy after one quarter, and again after two-quarters, of completion of the mailing. The MCS Pharmacy Department monitored whether or not the physician added the Bronchodilator or the Corticosteroid to the patient therapy. **Outcome and Monitoring** **1.** MCS examined the improvement in this HEDIS measure to assess the impact of our initiative. The expected outcome is to improve the compliance of the HEDIS Measure by increasing the percentage of enrollees with COPD who receive a Bronchodilator or Corticosteroids for better COPD management. The success of this initiative was measured also by the practitioner and member with the interventions. The rate is monitored and compared with the MA National Mean. The MA National Mean is considered the benchmark for this measure. The baseline was HEDIS 2015 rates. **2.** In CY 2016, a total of 513 providers were identified, and received the intervention. Additionally, a total of 843 enrollees were identified and received the intervention regarding Bronchodilators and Corticosteroids. In 2017, a total of 116 providers and 89 enrollees received the intervention for Bronchodilators. Regarding Corticosteroids, in 2017, a total of 227 PCP and 204 SNP enrollees received the intervention. On an annual bases, MCS monitors HEDIS results to determine the improvement and evaluates and initiates barrier interventions to positively effect and move the measure. Additionally, Pharmacy reports are included in the UM Program Evaluation and QI Program Evaluation, and are presented in the Quarterly UM and QI Committee Meetings for discussion. **3.** In addition, the expected outcome was to improve the Pharmacotherapy Management of COPD Exacerbation Measure when compared with the baseline HEDIS 2015 result of .97% (SNP 002). The rates for this measure increased for each of the SNP PBP's for HEDIS 2018. HEDIS 2018 is a measurement of Calendar Year 2017 overall rates. **a.** For PBP 002: In HEDIS 2016, the rate for Bronchodilator use increased when compared to HEDIS 2015 (baseline). However, this was not the same for the Systemic Corticosteroid, which showed a decreased in 2016, when compared to HEDIS 2015. A decrease was reported in 2017, with an increase in HEDIS 2018. In HEDIS 2018 the rate was still lower than the SNP National Mean benchmark; however, the HEDIS 2018 rate was higher when compared with HEDIS 2017, and when compared to the baseline, demonstrating an improvement in the use of Bronchodilator. The Corticosteroid rate for HEDIS 2016 decreased when compared to the baseline year; and another decrease was reported for HEDIS 2017. While the HEDIS 2018 rate was under the SNP National Mean for both measures, there was a significant improvement reflected by the increase in both measures for HEDIS 2018.

IPRO Recommendation	MCO Response
	b. For PBP 017: The rates for HEDIS 2018 had an increase when compared to HEDIS 2017 for the first year of this PBP. While the SNP National Mean was higher than the MCS achieved rate; the Corticosteroid use rate for this PBP was higher than other MCS PBP's in previous years. **c.** Other SNP PBP's active in CY2015 were closed, however interventions were in place when active. i. For PBP 019: In HEDIS 2017, the rate was lower than the SNP National Mean. This was the only year for this PBP. ii. For PBP 009: The HEDIS 2015 rate showed an increase and was the highest rate. The rate showed a decrease in HEDIS 2016, which was the last season of this PBP. The rates were lower than the SNP National Mean. iii. For PBP 010: The rates decreased for this PBP since HEDIS 2015; and were lower than the SNP National Mean. This was the last season for this PBP. **4.** From CY 2017 Q3 and early 2018, significant challenges related to the devastating Hurricane Maria aftermath contributed to significant barriers requiring additional coordination, community resource coordination, and support and best efforts, to complete proposed tasks and achieve the set goals. **Future Actions/Plans** **1.** MCS will continue the interventions with enrollees and providers to increase the outcome and monitor the measure improvement and Compliance Rate. MCS will continue with the integration of information technology to support QI initiatives. MCS will also continue the identification of possible emerging barriers and the adoption of best practices to continue to improve the measure.
• Measures in need of improvement for MCS include: Disease Modifying Anti-Rheumatic Drug Therapy	**Initial Plan of Action and How Was This Accomplished** **1. Preventive Reminders - Wellness and Health Promotion Department** **a)** MCS has ongoing educational initiatives to educate enrollees about management and treatment of Rheumatoid Arthritis to promote compliance with the quality measure. To improve this indicator in CY 2016 and CY 2017, the MCS Wellness and Health Promotion Department performed educational interventions to the general population and also interventions addressing targeted enrollees and providers. **b)** In CY2016 and CY2017 MCS sent a preventive reminder postcard to identified member in non-compliance status with the Rheumatoid Arthritis Management Measure. **c)** MCS sent a preventive reminder letter twice a year on CY 2016 and CY 2017, to the identified population including Drug Therapy for Rheumatoid Arthritis. **d)** Also, an educational capsule of Rheumatoid Arthritis was published in the Second Edition of the Cuídate Magazine, an MCS Health and Wellness publication, in 2016.

IPRO Recommendation	MCO Response
	2. Rheumatoid Arthritis Project - Premium Management and IPA Management Departments **a)** The Premium Management Department performed various interventions related to Rheumatoid Arthritis. The initiatives developed by the Premium Management and IPA Management Departments during CY 2016, CY 2017 and CY 2018, address providers and non-compliant enrollees with Rheumatoid Arthritis. These initiatives are: **1.** MCS identified enrollees in not compliance with Disease Modifying Anti-Rheumatic Drug Therapy and implemented a project to support the non-compliant member and their providers to improve the measure compliance rate ensuring the continuity of care. **2.** MCS identified non-compliant enrollees with Disease Modifying Anti-Rheumatic Drug Therapy and implemented projects in conjunction with the medical groups (IPAs) through preventive clinics. **3.** MCS offered education sessions to our providers and their respective medical staff about the compliance with Disease Modifying Anti-Rheumatic Drug Therapy in enrollees with Rheumatoid Arthritis. **3. Pharmacy Quality Initiatives- Pharmacy Department** **a)** MCS has ongoing Pharmacy quality projects to monitor proper treatment to enrollees with Disease Modifying Anti-Rheumatic Drug Therapy. **b)** This measure consists of the percentage of enrollees 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD). **c)** In CY 2016, CY 2017 and CY 2018, MCS sent letters to encourage identified members diagnosed with rheumatoid arthritis that was not prescribed a DMARD to get a DMARD. Letters were sent to their Primary Care Physician managing the condition. MCS identified the population with this diagnosis and measured the therapy after one quarter, and again, after two-quarters, of completion of the mailing. **Outcome and Monitoring** **1.** The expected outcome is to improve pharmacotherapy management of rheumatoid arthritis. MCS examined the improvement in the HEDIS measure to assess the impact of the initiative. The success of the initiative was measured also by the practitioner and member through interventions. The strategies and initiatives are continually monitored during the year to improve the Compliance Rate. **a.** In HEDIS 2015, the result was 63.54% for the MCS population. In the following years, MCS has been improving the Compliance Rate, even exceeding the MA National Mean.

IPRO Recommendation	MCO Response
	b. The rates for this measure are at Health Plan level. In HEDIS 2015, the rate for this measure for the Health Plan was below the MA National Mean. However, the rate increased in HEDIS 2016 when compared to the 2015 baseline rate. In HEDIS 2017, the rate showed a slight decrease; however, a significant improvement was reported for HEDIS 2018. For HEDIS 2018, measuring Calendar Year 2017, the rate was higher than the MA National Mean demonstrating the success of the multiple interventions. **2.** In August 2016, a preventive reminder post card was sent by the Education and Wellness Department to 1,621 SNP identified enrollees with Rheumatoid Arthritis. **3.** A preventive reminder letter to non-compliant beneficiaries was sent in July 2016 to 28,537 SNP enrollees and again in November 2016 to 67,776 SNP enrollees. **4.** The Cuídate Magazine was sent in October 2016 to 105,021 SNP enrollees with an educational capsule of Rheumatoid Arthritis. **5.** In December 2017, a preventive reminder post card was sent to 4,034 SNP identified enrollees with Rheumatoid Arthritis. **6.** A preventive reminder letter to non-compliant beneficiaries was sent in May 2017 to 65,649 SNP and again in December 2017 to 69,910 SNP enrollees. **7.** For CY 2017 The Cuídate Magazine mailing was cancelled due to Hurricane Maria, but it was printed and distributed amongst the service centers and MCS educational activities. MCS monitors HEDIS results to determine the improvement in the measure. **8.** In 2016, a total of 198 providers received the Pharmacy intervention. In 2017, a total of 620 providers received a letter and in CY 2018, a total of 279 providers received this intervention. Pharmacy reports are included in the UM Program Evaluation and QI Program Evaluation and are also discussed in quarterly UM and QI Committee Meetings. In CY 2016, a total of 198 enrollees were identified, and for 2% of them, the therapy was added. Similarly, in CY 2017, 620 enrollees received the intervention, and for 2.3% of them, the therapy was added. In CY 2018, 279 enrollees received the intervention and the therapy was added for 3% of them. **9.** Providers and their medical staff were educated on Disease Modifying Anti-Rheumatic Drug Therapy in enrollees with Rheumatoid Arthritis measure and strategies to be in compliance. **a.** In CY 2016, a total of 4,460 participants received the training, CY 2017, 5,120 participants received the training, and in CY 2018, a total of 5,898 were trained.

IPRO Recommendation	MCO Response
	b. The educational activities were supported by different components to validate and monitor the learning of the participants such as: attendee's registry, feedback evaluations, satisfaction surveys, physician's education interventions scorecards. **10.** The Premium Management Department staff meets with each projects staff monthly to discuss the results of the reports and establish Corrective Action Plans, if applicable. **11.** The Gaps in Care Reports for the IPAs and PCPs include the Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis Measure compliance. This status is available through a Provider Portal and an electronic tool called Provinet, which is accessible to the providers to monitor their progress of improvement. All this information is shared through our Provider Portal called Provinet. **12.** The IPA/PCP Management Department conducts monthly meetings with IPAs to monitor the progress of their respective Work Plan indicators, including this measure. **13.** MCS PCPs Compensation Plan for CY2016-2018 includes this measure to promote the compliance among PCPs. **14.** In 2017 and early 2018, significant challenges related to the devastating Hurricane Maria aftermath contributed to significant barriers requiring additional coordination, community resources coordination, and support and best efforts, to complete proposed tasks and achieve the set goals. **Future Actions/Plans** **1.** Continue the intervention with enrollees and continue to monitor the indicator, and trends, to develop new strategies and new barrier interventions. Continue to monitors HEDIS results to determine the rate of improvement.
• Measures in need of improvement for MCS include Potentially Harmful Drug-Disease Interactions in the Elderly.	**Initial Plan of Action and How Was This Accomplished** **1. Health Risk Annual Assessment - Premium Management Department** **a)** The Premium Management Department performed interventions addressing providers and non-compliant enrollees. The targeted enrollees list include non-compliant enrollees with Annual Medication Review included in the Comprehensive Health Risk Assessment tool. Potentially harmful drugs are reviewed as part of the Medication Review. **b)** In CY 2015, MCS launched the eCHRA electronic version for the health risk annual assessment. This version included a prepopulated list of current medications to promote revision of any potentially harmful drug prescribed. **c)** From CY 2015 to CY 2018, education was given to MCS Participant Providers and their medical staff about the need to complete the HRA tool, and the need to complete the Medication Review. The guidelines for

IPRO Recommendation	MCO Response
	the Medication Review include information on how elderly patients are vulnerable to drug interactions because of age related physiological changes, and increased risk for disease associated with aging and the consequent increase in medication use. **Outcome and Monitoring** **1.** The expected outcome is to reduce the percentage of enrollees with 65 years of age and older, who have evidence of an underlying disease, condition, or health concern, and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with, or after, the diagnosis. MCS examined the improvement in this HEDIS measure to assess the impact of the initiative. The success of the initiative was measured also by the practitioner with interventions. The strategies and initiatives are monitored during the year to improve the compliance rate. The rate is monitored and compared with the MA National Mean, considered the benchmark for this measure. The baseline was HEDIS 2015. **2.** For CY 2015, a total of 797 Physicians and 1,041 staff members received training on the CHRA, including the Medication Review. In CY 2016, 536 and 240 respectively, for CY 2017, a total of 833 Physicians and 456 staff members received training, and in CY 2018, 585 Physicians and 292 of their staff members received the information on CHRA and Medication Review. **3.** Additional education efforts were sent through the Eblast, electronic emails. In CY 2015 educational materials on Medication Review were sent to a total of 1,930 Physicians. In CY 2016, 2,283 Physicians received this material, and in CY 2017, information on the CHRA was sent to 1,753 Physicians. In CY 2018, information was sent to 1,751. In addition, in CY 2018, additional information about the HRA Tool was sent to 2,576 Physicians. **4.** A letter to instruct providers about the Medication Review was sent in CY 2015 and in CY 2016 and again in CY 2018. **5.** The educational activities were supported by different components to validate and monitor the learning of the participants such as: attendee's registry and feedback evaluations. **6.** This measure is composed of a 3 part measure: **a)** The Total or Composite: i. For HEDIS 2015, all rates were higher than the MA National Mean of 41.46%, demonstrating the need for improvement (PBP 002- 63.97%), please see attached table. In HEDIS 2017, the composite measurement showed a decrease demonstrating improvement (BP 002: 60.69%), however the rate was higher than the MA National Mean for all PBP's. For HEDIS 2018, there was a slight improvement in both reported SNP PBP's with lower rates than HEDIS 2017. A lower rate represents better performance (PBP 002: 60.36% and PBP 017:67.18%) **b)** Falls & Anticonvulsants, Nonbenzodiazepine hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines or Tricyclic Antidepressants:

IPRO Recommendation	MCO Response
	i. For PBP 002: there was an increase in the HEDIS 2016 rate when compared to HEDIS 2015 rate. For HEDIS 2017 and HEDIS 2018, the rate showed an improvement, (PBP 002: 58.24%). A lower rate represents better performance. The rates continue to be higher than the MA National Mean. ii. For PBP 017: the rates were higher than MA National Mean, showing an increase, thus representing a lower performance than the previous year, where HEDIS 2017 (66.36%) and HEDIS 2018 (67.27%) rates were compared. iii. Other SNP PBP's active in CY2015 were closed, however interventions were in place when active for shorter time due to the life cycle of the PBP. 1. For PBP 009: the measurement showed a slight increased from HEDIS 2015 to HEDIS 2016, the rates were higher than the MA National Mean, representing the need for improvement. 2. For PBP 010: the measurement showed a decrease for HEDIS 2016 when compared to HEDIS 2015, HEDIS 2016, showing an improvement in the last season of the PBP. Although, the rates were higher than the MA National Mean. 3. For PBP 019: for this PBP, the rates were lower when compared with the results of the other PBP's reported in HEDIS 2016 and HEDIS 2017, demonstrating a better rate for this PBP. However, the rate was still higher than the MA National Mean, and this was the last season of this PBP. **c)** Dementia Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine hypnotics or Anticholinergic Agents: i. For PBP 002: there was an increase in 2016, when compared to the 2015 rate, and the rates were above the MA National Mean. In HEDIS 2017 and HEDIS 2018, the rate showed a decrease representing an improvement for both years, as a lower rate represents better performance. However, the rates continue to be higher than the MA National Mean. We saw a reduction in rate for PBP 002 from 75.69% in HEDIS 2015 to 72.32% for HEDIS 2018. ii. For PBP 017: the rates were higher than the MA National Mean; however, the rates showed an improvement when 2017 and 2018 rates were compared. 79.11% vs 78.95% respectively. iii. Other SNP PBP's active in CY 2015 were closed; however, interventions were in place when active for shorter time due to the life cycle of the PBP.

IPRO Recommendation	MCO Response
	1. For PBP 009: the measurement showed a slight decrease when comparing HEDIS 2015 to HEDIS 2016, demonstrating improvement in the last year of the PBP (75% vs 74.92%). However, the rates were higher than the MA National Mean. 2. For PBP 010: the measurement showed an increase in HEDIS 2016 (78.4%) when compared to HEDIS 2015 (69.58%), HEDIS 2016 was the last year of this PBP. The rates were higher than the MA National Mean. 3. For PBP 019: for this PBP, the rates (71.43%) were lower when compared with the results of the other PBP's active in 2016 and 2017, demonstrating a better rate for this PBP. However, the rate was higher than the MA National Mean and this was the last season for this PBP. **d)** Chronic Kidney disease and Cox-2 Selective NSAIDs or Non-aspirin NSAIDs: i. For PBP 002: there was an increase in 2016 when compared to the 2015 rate. The rates were above the MA National Mean, in HEDIS 2017 and HEDIS 2018, the rate showed a decrease representing an improvement for both years. A lower rate represents better performance; however, the rates continue to be higher than the MA National Mean. We saw a reduction of PBP 002 from 33.11% in HEDIS 2015 to 27.35% for HEDIS 2018. ii. For PBP 017: the rates were higher than the MA National Mean; however, the rates showed an improvement when 2017 and 2018 rates were compared, 37.33% vs 36.78% respectively. iii. Other SNP PBP's active in CY2015 were closed; however, interventions were in place, although active for shorter time, due to the shorter life cycle of the PBP. 1. For PBP 009: for this PBP there was no reporting data for HEDIS 2015. In HEDIS 2016 (30.23%) the measurement was lower than previous year results for other PBP's, demonstrating a better rate. That was the last season for this PBP. The rate was higher than the MA National Mean. **7.** From CY 2017 Q3 and early 2018, significant challenges related to the devastating Hurricane Maria aftermath contributed to significant barriers requiring additional coordination, community resources coordination, and support and best efforts, to complete proposed tasks and achieve the set goals. **Future Actions/Plans** **1.** Continue to monitors HEDIS results to determine the improvement. For CY 2019 additional interventions are going to be considered to promote improvement. New interventions with the Pharmacy Department and Transition of Care Unit will occur. Identification of at-risk patients to refer to complex care management will also be incorporated.

Triple-S Platino

Table 43: Triple-S Platino's Response to Recommendations

IPRO Recommendation	MCO Response
Evaluate HEDIS performance against the Quality Compass™[20] benchmarks for measures that are in need of improvement. Develop and implement targeted interventions to improve performance.	**Initial Plan of Action –** Triple S evaluates HEDIS performance against Star Ratings Program thresholds and in a weekly basis monitors trends. **How was this accomplished?** Since 2016, Triple S partnered with an NCQA HEDIS certified vendor which delivers services through a platform from which the health plan obtains reports daily, if needed. In addition, member and provider initiatives were developed and successfully implemented. Some examples, but are not limited to: PCP compensation plan tied to HEDIS metrics performance -Preventive Care member rewards (based on HEDIS measures) -Prospective HEDIS approach where clinical staff completes medical record review for supplemental data capture -Development and implementation of a collaborative platform to support physicians by making reports and member clinical information available 24/7 for a better member managed care. -Bienestar Clinics – Health fairs to perform preventive services to members. -Breast Cancer Screening Clinics for easy access to women in need of a mammogram. -Communication to members and physicians on preventive screenings importance. Such as bulletins, newsletters, flyers, and face to face interventions. -Face to face education on HEDIS measures to physicians and medical groups. -Member retreats with a screening unit to complete preventive tests such as A1c, kidney disease monitoring, Eye Exam, FOBT, among others. **Outcome and Monitoring -** Please refer to attachment were graphics clearly demonstrate that the above implemented strategies have been key in measure improvement over the past years. **Future Actions/Plans** Triple S is constantly analyzing measure rates and improvement alternatives to render quality services to our membership. Participation in different forums is recurrent to learn best practices, implement, and monitor.
Ensure that performance improvement projects are methodologically sound and measurement indicators and results are clearly defined and consistently applied	**Initial Plan of Action -** TSA will implement the auditor's recommendation and will put together an overall QI Evaluation report that pulls together all the information currently presented in multiple area specific evaluation reports. Including a summation of all annual activities, accomplishments for the current year and opportunities for the coming year. **How was this accomplished?** - Triple S developed an overall QI Evaluation Report that outlined all annual activities, accomplishments for the current year and opportunities for the coming year to improve the annual evaluation. **Outcome and Monitoring -** In 2016, the quality improvement activities and initiatives in overall were effective. Both were aimed to provide the highest quality services and access to healthcare for our population. Nevertheless, some barriers and

[20] Quality Compass is a registered trademark of the National Committee for Quality Assurance (NCQA).

IPRO Recommendation	MCO Response
throughout the life of the PIP. The MCO should maintain a table of indicators, goals and results to track progress over time. PIPs should be evaluated on an ongoing basis.	limitations were identified in each operational area such as internal staffing changes, software applications and vendor difficulties, among others. TSA assessed these issues and will work with new initiatives to improve processes. **Future Actions/Plans -** Revise strategies and work plan to ensure compliance. Ensure proper documentation of processes, throughout the use of established templates, forms, application and development of specific policies.
Examine the regulatory requirements designated not fully met and take corrective action to achieve compliance, especially for those with repeated deficiencies.	**2016 Grievance System (**1) element deemed as "Substantial Compliance": **1. <u>Recommendation for Triple S -</u>** Triple S should implement a system to ensure that each enrollee who receives a notice of denial is informed, at the time of the initial notice of action, as well as at the time of the appeal acknowledgement letter, of the opportunity, (before and during the appeals process), to examine the case file, including medical records, and any other documents and records considered during the appeals process. **Initial Plan of Action -** TSA will update the notice of action letter to ensure that each enrollee who receives a denial notice is informed, of his right, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.
	2016 Measurement and Improvement - (4) elements deemed as "Substantial Compliance": **1. <u>Recommendation for Triple S</u> -** The recommendations from the previous compliance review stand. The MCO should submit evidence of monitoring consistent application of guidelines by MCO staff making prospective, concurrent and retrospective review determinations, and include all monitoring results in an overall QI Evaluation Report. At that time, the MCO stated an overall QI Evaluation Report would be implemented in CY 2016. **Initial Plan of Action -** For CY2016 we will implement IPRO recommendation to develop an overall QI Evaluation Report, it will include all the information presented as part of the information submitted. Also, will include evidence of monitoring perform to ensure consistent application of guidelines by TSA's staff making prospective, concurrent and retrospective review **How was this accomplished? -** Triple S developed an overall QI Evaluation Report that outlined all annual activities, accomplishments for the current year and opportunities for the coming year to improve the annual evaluation. **Outcome and Monitoring -** In 2016, the quality improvement activities and initiatives in overall were effective. Both were aimed to provide the highest quality services and access to healthcare for our population. Nevertheless, some barriers and limitations were identified in each operational area such as internal staffing changes, software applications and vendor difficulties, among others. TSA assessed these issues and will work with new initiatives to improve processes **Future Actions/Plans -** Revise strategies and work plan to ensure compliance. Ensure proper documentation of processes, throughout the use of established templates, forms, application and development of specific policies. **2. <u>Recommendation for Triple S</u>** While all required elements seem to exist, an evaluation of overall QAPI impact and effectiveness would be achieved by a comprehensive review of all activities – each including performance, analysis and next steps – and concluding with a summarization of accomplishments and opportunities for improvement.

IPRO Recommendation	MCO Response
	Initial Plan of Action - Auditor's recommendation will be implemented: A comprehensive review of all activities – each including performance, analysis and next steps – and concluding with a summarization of accomplishments and opportunities for improvement will be included in the QAPI evaluation to ensure that impact and effectiveness is achieved and well documented. **How was this accomplished? -** Triple S developed an overall QI Evaluation Report that outlined all annual activities, accomplishments for the current year and opportunities for the coming year to improve the annual evaluation. **Outcome and Monitoring** - In 2016, the quality improvement activities and initiatives in overall were effective. Both were aimed to provide the highest quality services and access to healthcare for our population. Nevertheless, some barriers and limitations were identified in each operational area such as internal staffing changes, software applications and vendor difficulties, among others. TSA assessed these issues and will work with new initiatives to improve processes **Future Actions/Plans -** Revise strategies and work plan to ensure compliance. Ensure proper documentation of processes, throughout the use of established templates, forms, application and development of specific policies. 3. **Recommendation for Triple S -** CCIP/QIP information as submitted to CMS should be summarized in the MCO annual review of the impact and effectiveness of the QAPI program. CCIP/QIP activities should be entered in Work Plans, and regularly presented/evaluated in the Quality Committee. **Initial Plan of Action -** Auditor's recommendation will be implemented: PIP Results –accompanied by barriers, action plans, best practices and lessons learned – will be included in TSA's annual review of the impact and effectiveness of the QAPI program. Also, we will include a summary of TSA's CCIP/QIP in the annual review of the impact and effectiveness of the QAPI program. Also, CCIP/QIP activities will be entered in TSA's Work Plans, and regularly presented/evaluated in the Quality Committee. **How was this accomplished? -** Triple S developed an overall QI Evaluation Report that outlined all annual activities, accomplishments for the current year and opportunities for the coming year to improve the annual evaluation. **Outcome and Monitoring -** In 2016, the quality improvement activities and initiatives in overall were effective. Both were aimed to provide the highest quality services and access to healthcare for our population. Nevertheless, some barriers and limitations were identified in each operational area such as internal staffing changes, software applications and vendor difficulties, among others. TSA assessed these issues and will work with new initiatives to improve processes **Future Actions/Plans -** Revise strategies and work plan to ensure compliance. Ensure proper documentation of processes, throughout the use of established templates, forms, application and development of specific policies. 4. **Recommendation for Triple S -** The Plan should put together an overall QI Evaluation report that pulls together all the information currently presented in multiple area specific evaluation reports. Adding a summation of all annual activities, accomplishments for the current year and opportunities for the coming year would improve the annual evaluation.

IPRO Recommendation	MCO Response
	Initial Plan of Action - TSA will implement the auditor's recommendation and will put together an overall QI Evaluation report that pulls together all the information currently presented in multiple area specific evaluation reports. Including a summation of all annual activities, accomplishments for the current year and opportunities for the coming year. **How was this accomplished? -** Triple S developed an overall QI Evaluation Report that outlined all annual activities, accomplishments for the current year and opportunities for the coming year to improve the annual evaluation. **Outcome and Monitoring -** In 2016, the quality improvement activities and initiatives in overall were effective. Both were aimed to provide the highest quality services and access to healthcare for our population. Nevertheless, some barriers and limitations were identified in each operational area such as internal staffing changes, software applications and vendor difficulties, among others. TSA assessed these issues and will work with new initiatives to improve processes **Future Actions/Plans -** Revise strategies and work plan to ensure compliance. Ensure proper documentation of processes, throughout the use of established templates, forms, application and development of specific policies.
	2016 **Program Integrity** – (1) element deemed as "Minimal Compliance" and (1) "non-compliance" **1.** **Recommendation for Triple S** - The plan should add the contract language into a policy or procedure: "Sixty (60) days after the date of the agreement the Company must submit to ASES Compliance Office copy of the policies and procedures for identifying and tracking potential provider fraud cases, for conducting preliminary and full investigation and for referring cases of suspected fraud to an appropriate law enforcement agency. The Compliance Plan should be developed in accordance with 42 CFR 438.608." **Initial Plan of Action -** Please refer to Page 37 *Section 1: Purpose* for added language in the Program Integrity Plan (PIP) and the evidence of submission to ASES. **How was this accomplished? -** Please refer to updated Program Integrity Plan (PIP) Page 18 *Section b) Methods to prevent and detect fraud, waste and abuse – 3rd bullet*. **1.** **Recommendation for Triple S** - This requirement is not found in the Program Integrity Plan (PIP): "The PIP must define the mechanism to monitor frequency of encounters and services rendered to patients billed by providers". **Initial Plan of Action -** TSA agrees to auditor's review determination. Accordingly, TSA immediately updated its Program Integrity Plan. Updated PIP attached for your reference. Refer to page 11 section b – 3rd bullet. **How was this accomplished? -** TSA agrees to auditor's review determination. Accordingly, TSA immediately updated its Program Integrity Plan. Updated PIP attached for your reference. Refer to page 30 – section 1 – 3rd paragraph. **Recommendation for Triple S** This requirement is missing from a policy or procedure: "The organization will select a sample to perform independent reviews to verify that recipient's services billed by providers (as well as encounters under capitated environment) were indeed rendered. This review will be performed through confirmations to beneficiaries". **Initial Plan of Action -** TSA agrees to auditor's review determination. Accordingly, TSA immediately updated its Program Integrity Plan. Updated PIP attached for your reference. Refer to page 11 section b – 4th bullet.

IPRO Recommendation	MCO Response
	How was this accomplished? - Please refer to updated Program Integrity Plan (PIP) Page 18 *Section b) Methods to prevent and detect fraud, waste and abuse – 4th bullet*.
	2016 Enrollee Rights **2016 QAPI Structure and Operations** Based on report issued on December 2, 2016, all elements were deemed as Full Compliance on both reports. No further actions needed.