Mercer

Government Human Services Consulting

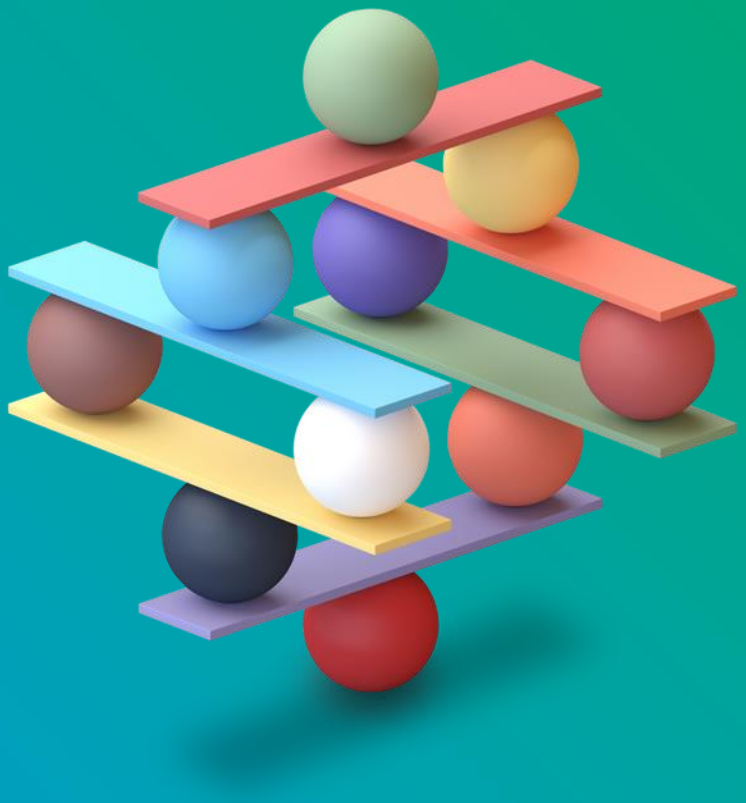
Puerto Rico Health Insurance Administration

External Quality Review Technical Report

Contract Years 2018–2022

Puerto Rico

February 27, 2024



welcome to brighter

A business of Marsh McLennan

Contents

Section 1

Introduction

The Balanced Budget Act of 1997 (BBA) was an omnibus legislative package enacted by the United States Congress with the intent of balancing the federal budget by 2002. Among its other provisions, this expansive bill authorized states to provide Medicaid benefits (except to special needs children) through managed care plans. Regulations were promulgated, including those related to the quality of care (QOC) and service provided by managed care plans to Medicaid beneficiaries. An associated regulation requires that an External Quality Review Organization (EQRO) conduct an analysis and evaluation of aggregated information on quality, timeliness, and access to the healthcare services that a managed care plan or its contractors furnish to Medicaid recipients. The EQRO creates plan specific reports and as part of its analysis and evaluation activities, the EQRO is required to submit a technical report to the state Medicaid agency, which in turn submits the report to the Centers for Medicare & Medicaid Services (CMS). The report is also posted to the Medicaid agency website.

The Government of Puerto Rico Medicaid Program (PRMP) entered into an agreement with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to perform External Quality Review (EQR) services related to its Medicaid program. All Puerto Rico managed care organizations (MCOs), Government Health Plans Government Health Plans (GHPs), and Platino Medicare Advantage Organizations (MAO), participate in EQR. GHPs reviewed include First Medical Health Plan, Inc (FMHP), Medical Card System (MCS), MMM Multi Health, LLC (MMM), Plan de Salud Menonita (PSM), Triple S Salud (Triple S) and Molina Healthcare of Puerto Rico (Molina)[1]. Platino plans reviewed include Humana Health Plans of Puerto Rico, Inc. (Humana), MCS, MMM Platino, and Triple S Platino.

Scope of the External Review Process

Mercer conducted a retroactive and current review of the following EQR activities for Puerto Rico's MCOs:

EQR Activity	Description	Plans Reviewed
Protocol 1	Performance Improvement Plan (PIP) validation for PIPs underway during calendar years (CYs) 2018–2022	GHPs
Protocol 2	Performance measure (PM) validation for PMs calculated using data from CYs 2018–2022, including an Information Systems Capability Assessment (ISCA)	GHPs

[1] Molina review period is 2018-2020 when they exited Puerto Rico Medicaid Program.

EQR Activity	Description	Plans Reviewed
PM Rate Reporting	PM rate reporting for and comparison to National Benchmarks	GHP CYs 2018–2022 Platino Plans CYs 2019–2022
Protocol 3	Validation of compliance with all 14 federal standards and contract requirements related to member access to timely, quality healthcare during CY 2022	GHPs Platino plans
Program Integrity (PI)	PI review for CY 2022 to Quarter 2 2023 (June 30, 2023)	GHPs Platino plans
Network Adequacy	Network adequacy review for the 2023 plans against the 2023 contract	GHPs

Section 2

EQR Overview

EQR Objectives

Mercer's objective for the EQR was to assess Puerto Rico health plan performance toward achieving Puerto Rico's Quality Strategy goals, which are:

- To improve preventative care screening, access to care, and utilization of health services for all Medicaid, federal and State, and Children's Health Insurance Program (CHIP) Enrollees.
- To improve QOC and health services provided to all Medicaid Enrollees through the High Cost, High Needs (HCHN) Program.
- To improve Enrollee satisfaction with provided services and primary care experience.

To achieve this objective, Mercer performed the mandatory EQR activities which are intended to improve Puerto Rico's ability to oversee and manage the contracted health plans and help improve their performance with respect to quality, timeliness, and access to care. The mandatory activities include validation of PIPs, validation of PMs and a compliance review of Medicaid and CHIP managed care regulations. This report presents the results as required by 42 CFR 438.364. The objectives of this review included:

- Assessing the quality of services provided, the timeliness of services provided, and access to care and recommendations to the MCOs, MAOs, and Puerto Rico for continued improvement.
- Comparison of PM results with national benchmarks.
- Evaluation of MCO PIPs.
- Assessing implementation of corrective action plan (CAP) activities

Technical Methods for Data Collection and Analysis

As a consulting firm, Mercer has access to individuals with expertise in a variety of fields. For this EQR process, Mercer chose a specifically designated team with a variety of specialties and talents that could meet the requirements of the EQR process.

The methodology used by Mercer, during this review process, was organized into five critical phases presented in the following diagram.

Request for Information

Mercer utilized a request for information (RFI) to acquire information specific for all areas of the review. Mercer received information electronically and reviewed all documents submitted

over a series of weeks. The information was organized on the SharePoint site into folders and subfolders, coordinating with the data request format. During the on-site review phase, additional information was collected; a small number of outstanding data needs remained. At the close of the on-site review process, Mercer summarized the outstanding information needs and the MAOs and MCOs submitted additional information for further review and consideration following the on-site visit.

Review Tool

Mercer utilized a comprehensive EQR compliance review tool (tool) adapted from CMS protocols for the compliance section of the review. The tool design included State standards reflecting key issues and Puerto Rico priorities. Additionally, the tool assisted the reviewers in coordinating the review process in a logical manner, consistent with the flow of BBA regulations. Mercer's desk review results helped to focus observations and interviews to gather additional information during the onsite review phase.

Analysis and Reporting

Information from all phases of the review process was gathered, and a comprehensive analysis was completed. Each EQR activity includes a scoring section which is defined in that section of the report.

Description of the Data Obtained

The data obtained for the annual review included, but was not limited to:

- Organizational charts, staffing locations, and staffing plans
- Oversight and monitoring of delegated agencies and delegated arrangements
- Audit tools and results
- Policies and procedures (P&Ps), workflows, desk processes, and other supporting documents
- Staff orientation, training plans, and handbook
- Grievance and appeal (G&A) P&Ps
- Enrollee materials, disenrollment procedures, and monitoring
- Utilization Management (UM) functions, protocols program description, work plan, and program evaluation
- Care Coordination screenings and assessments and management of Enrollees with Special Health Care Needs (SHCN)
- Network development and management plans
- Annual quality work plan and program description
- Provider and Enrollee satisfaction survey results
- Documentation and data used to support validation of PIPs and PMs

- Healthcare Effectiveness Data and Information Set (HEDIS®) audit documentation and results

In addition to the documentation reviewed, Mercer conducted interviews with MAO and MCO staff to assess consistency of responses across operational areas and documentation the health plan provided.

Conclusions Based on the Data Analysis

Mercer's reviewers used analytic questions such as those noted below during their review of the various EQR activities:

- PIP Validation: Did the MCO develop a PIP Aim Statement that was clear, concise, measurable, and answerable? Did the MCO clearly identify the population targeted for the PIP? Did the MCO use appropriate sampling methods? Did the MCO use appropriate variables to identify the performance of the PIP? Did the MCO incorporate a data collection plan specifying the data sources, data collected, how and when data is collected, cadence of data collection, staff responsible for collecting the data, and the instruments used to collect the data? Did the MCO implement a continuous QI process for analysis and interpretation of the PIP?
- PM Validation: How are PM data collected? Where are data used for PM stored? What are the sources for data used for PM calculation? How often are data exchanged with vendors supplying supplemental data? How are the files for HEDIS vendor software created and what controls are in place in to ensure the merged data files are accurate and complete? What processes are implemented to prevent loss of data when systems fail? What are your processes for preliminary rate calculations and how are they monitored? How does the MAO/MCO address changes to measures? If hybrid data collection methods are used, is collection done in house or outsourced? What training is provided to abstractors? What are the processes to ensure inter-rater reliability (IRR)? What is the MAOs/MCOs processes for vendor oversight and monitoring?
- Compliance Validation: Did the MAO/MCO supply documentation evidencing compliance with regulatory and contractual requirements? Did staff interviews demonstrate consistency with compliance?

Section 3
Validation of PIPs

Introduction

PIPs are required by CMS as an essential component of a MCO's quality program and are used to identify, assess, and monitor improvement in processes or outcomes of care. The objective of the validation process is to assess overall project methodology as well as the overall validity and reliability of the PIP methods and findings to determine confidence in the results. PIPs are validated in accordance with § 438.330 using the analytic approach established in CMS EQR Protocol 1. As required by CMS, Mercer is providing project-specific summaries using CMS Worksheet Number 1.11 from EQR Protocol 1, Validation of PIPs. The PIP Aim Statements are taken directly from the MCO's report(s) to Mercer, as are the improvement strategies, interventions, and performance indicator data. Mercer validated each of these projects, meaning that it reviewed all relevant parts of each PIP and made a determination as to its validity. Reviewers assigned a validation confidence rating, which refers to Mercer's overall confidence that the PIP adhered to acceptable methodologies for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of improvement or the potential for improvement. Recommendations offered were taken from the reviewers' rating forms. As is required by CMS, Mercer has identified MCO and project strengths as evidenced in the PIP. It should be noted that the Platino MAOs were not required to implement PIPs, therefore are not included in this review section.

Puerto Rico has mandated the following PIPs for GHPs in 2018–2022[2]:

Topic
One clinical care project in the area of increasing fistula use for Enrollees at risk for dialysis
One clinical care project in the area of behavioral health (BH)
One administrative project in the area of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
One administrative project in the area of co-location and reverse co-location of physical health (PH) and BH, and their integration

Review Process

Methodology

The summary results and recommendations presented below are based on EQR PIP Validation Protocol 1. Validation of PIPs which includes:

- Review the Selected PIP Topic
- Review the PIP Aim Statement

[2] Molina review period is 2018-2020 when they exited Puerto Rico Medicaid program.

- Review the Identified PIP Population
- Review the Sampling Methodology
- Review the selected PIP Variables and PMs
- Review the Data Collection Procedures
- Review Data Analysis and Interpretation of PIP Results
- Assess the Improvement Strategies
- Assess the Likelihood that Significant and Sustained Improvement Occurred
- Perform Overall Validation and Reporting of PIP Results

The EQRO provides an overall validation rating of the PIP results. The validation rating refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of improvement.

Confidence in Reported Results			
High	**Moderate**	**Low**	**No Confidence**
Fully compliant with standard protocol.	Substantially validated and only minor deviations from standard protocol.	Deviated from protocol such that the reported results are questionable.	Deviated from protocol such that reported results are not validated.

Findings by MCO

Overall, the MCOs submitted PIP project plans providing goals and objectives while demonstrating commitment to aligning improvement projects, when optimal, with respected industry standards, such as those set by Health and Human Services (HHS) and CMS priority areas. Additionally, all MCOs used HEDIS metrics and adhered to National Committee for Quality Assurance's (NCQA's) HEDIS Technical specifications when applicable, as well as engaged HEDIS-certified vendors when capturing HEDIS metrics for their PIPs. Many PIPs generally demonstrated year-to-year improvements across the PIPs suggesting ongoing dedication to quality and enhancement, however in most cases analysis for statistical significance in improvement was not identified.

The MCOs provided comprehensive PIP descriptions and adhered to most phases of the protocol. All of the MCOs have the opportunity to enhance their PIP Aim Statements by defining the PIP improvement strategy, target population, measurable impact, and time period, specifically delineating the baseline year. The MCOs also struggled to consistently describe and memorialize their data interpretation, including effectiveness of interventions and incorporation of lessons learned.

Comparative Analysis

GHP PIP Confidence Ratings for Adherence to Acceptable Methodology for All Phases by Project Topic

Plan	Increasing Fistula Use	Clinical Care Project — BH	Administrative Project — EPSDT	Administrative Project Co-location and Reverse Co-location of PH and BH and Their Integration
FMHP	Moderate	Moderate	Low	Moderate
MMM	Moderate	Moderate	Moderate	Moderate
Molina	Moderate	Moderate	Moderate	Low
PSM	Low	Moderate	Moderate	Low
Triple S	Moderate	Moderate	Moderate	Moderate

GHP PIP Confidence Ratings for Evidence of Significant Improvement by Project Topic

Plan	Increasing Fistula Use	Clinical Care Project — BH	Administrative Project — EPSDT	Administrative Project Co-location and Reverse Co-location of PH and BH and Their Integration
FMHP	Moderate	Low	Low	Moderate
MMM	Moderate	Moderate	Low	Moderate
Molina	Moderate	Moderate	Low	Low
PSM	Low	Moderate	Low	Low
Triple S	Low	Moderate	Moderate	Moderate

Plan-Specific PIPs

Topic 1: Increasing Fistula Use for Enrollees at Risk for Dialysis

FMHP

1. General PIP Information
MCO Name: FMHP
PIP Title: Increase arterial venous fistula (AVF) use for Enrollees at risk for dialysis
PIP Aim Statement: Focus on members at risk for dialysis as strategy to improve AVF utilization.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☐ Both adults and children ☒ Other: Target age group not identified. ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, long-term services and support (LTSS), or pregnant women (please specify): FMHP Enrollees with chronic kidney disease (CKD) in Stage 3b, 4, and 5, registry in the Special Coverage High-Cost Conditions.
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
2. Improvement Strategies or Interventions
Educational activities through telephonic coaching to provide information on the importance of having functional permanent access at the initiation of dialysis therapy. Improve care coordination across providers, educating on best practices based on clinical guidelines. Link care management (CM) programs to promote AVF education in members at high risk for dialysis.

Utilize wellness, disease management, complex case management, UM, and Transitional CM programs to ensure Enrollees are educated on the benefit of having an AVF.

Coordinate Enrollee engagement to discuss clinical interventions according to the patient's stage.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator: Total Enrollee with CKD Stage 3–5 and total Enrollees with an AVF placement within after educational interventions.	CY 2017 however, not clearly articulated.	17.25%	CY 2022	18.86%	☒ Yes ☐ No ☐ Unknow due to lack of baseline data	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Sixth re-measurement

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

MCO strengths:

The PIP commendably set out four key objectives including the understanding of regional differences in fistula placement, enhancing care coordination and best practices, aligning contractual strategies for better AVF utilization rates, and educating both Enrollees and health professionals on CKD and AVF.

Despite challenges such as public health emergencies (PHEs) affecting provider access to Enrollees and providing services, FMHP pivoted and implemented strategies to ensure that FMHP efforts produced improvement in their PIP.

EQRO recommendations:

FMHP's PIP Aim Statements currently lack specificity and measurability, crucial for setting clear, actionable goals. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

For FMHP's PIP to effectively measure progress and outcomes, it is crucial to clearly articulate the baseline year and rate with each reporting cycle. This foundation is essential for accurate and meaningful analysis. It is recommended that FMHP identify the baseline year to ensure precise and meaningful analysis of the PIP's progress and outcomes.

FMHP's data analysis for the PIP did not demonstrate continuous QI techniques or effectively incorporate lessons learned. To enhance the effectiveness of FMHP's PIPs, it is recommended to adopt and implement continuous QI methodologies. These methodologies, such as Plan-Do-Study-Act (PDSA) or rapid cycle approaches, are crucial for incorporating lessons learned and identifying areas of opportunity within the PIP. Integrating these techniques will significantly improve the overall quality and outcomes of FMHP's PIPs.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended FMHP perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended FMHP consider this opportunity to include measures that capture Enrollee satisfaction or experience of care.

FMHP PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include an appropriate cultural and linguistic approach with the PIP process.

Data collection personnel qualifications were not clearly indicated in the PIP. It is recommended that FMHP consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

FMHP PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One clinical care project in the area of increasing fistula use for Enrollees at risk for dialysis.	Moderate Confidence: FMHP provided a comprehensive description and adhered to most phases of the protocol. FMHP has the opportunity to enhance the PIP Aim Statement by clearly defining the improvement strategy, target population, measurable impact, and time period. The PIP commendably set out four key objectives including the understanding of regional differences in fistula placement, enhancing care coordination and best practices, aligning contractual strategies for better AVF utilization rates, and educating both Enrollees and health professionals on CKD and use of AVF. However, the PIP analysis did not clearly state the interpretation of the data or analysis of interventions, and although the baseline appears to be CY 2017, it is not clearly articulated in the PIPs.

FMHP PIP	EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
One clinical care project in the area of increasing fistula use for Enrollees at risk for dialysis.	Moderate Confidence: FMPH provided data supporting improvement, however, the PIP's measurements over the years show notable fluctuations. The absence of a clearly defined baseline year makes it challenging to determine the trajectory of improvement from the outset however incremental gains were observed from the first measurement in 2017. The analysis and relation to successful improvement strategy was not clearly stated and inclusion of evaluation of statistical significance in improvement was not identified.

MMM

1. General PIP Information
MCO Name: MMM
PIP Title: PIP Fistula Use for Enrollees at Risk for Dialysis
PIP Aim Statement: To increase in 5% the rate of AVF placement among members with CKD Stage 4 during a three-year period. To increase by 5% beneficiaries with CKD Stage 4 who have had at least one visit to the nephrologist in the last 12 months during a three-year period.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).

Target age group (check one):
☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☐ Both adults and children. ☒ Other: Target age group not identified
***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify):
Beneficiaries with a diagnosis of CKD Stage 4 (ICD-10: N18.4) enrolled in Plan Vital of MMM and are listed under the Special Renal Coverage Registry.

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Intervention

Educational material.

Face-to-face visits with Primary Care Providers (PCPs).

Training directed to PCPs related to treatment guidelines for patients with CKD.

Provider Bulletins.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator #1: Beneficiaries with CKD Stage 4, who received at least one visit with a nephrologist during the measurement year (MY).	CY 2018	66.7%	CY 2021	79.3%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Quality Indicator #2: AV access placement services for beneficiaries diagnosed with CDK Stage 4.	CY 2018	2.7%	CY 2021	26.2%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Third re-measurement

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

MCO strengths:

MMM's PIP interventions successfully incorporated a range of strategies to enhance quality of care, including the distribution of educational materials, conducting face-to-face visits with PCPs, delivering presentations to Primary Medical Group (PMG) administrative staff in advisory board meetings, and providing targeted training to PCPs on treatment guidelines for patients with CKD.

MMM's selection of the PIP was informed by a thorough literature review that examined factual studies, best practices, and guidelines. This process allowed MMM to identify the precise area of opportunity.

Despite challenges from a PHE affecting provider access to Enrollees and the implementation of services, MMM continued to seek strategies to improve the PIP outcomes and effectively demonstrate improvement in the PIP.

EQRO recommendations:

MMM's PIP Aim Statements currently lack specificity and measurability, crucial for setting clear, actionable goals. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

MMM's data analysis for the PIP did not demonstrate continuous QI techniques or effectively incorporate lessons learned. To enhance the effectiveness of MMM's PIPs, it is recommended to adopt and implement continuous QI methodologies. These methodologies, such as PDSA or rapid cycle approaches, are crucial for incorporating lessons learned and identifying areas of opportunity within the PIP. Integrating these techniques will significantly improve the overall quality and outcomes of MMM's PIPs.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended MMM perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended MMM consider this opportunity to include measures that capture Enrollee satisfaction or experience of care.

MMM PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include an appropriate cultural and linguistic approach with the PIP process.

Data collection personnel qualifications were not clearly indicated in the PIP. It is recommended that MMM consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One clinical care project in the area of increasing fistula use for Enrollees at risk for dialysis.	Moderate Confidence: MMM provide a comprehensive description and adhered to most phases of the protocol. MMM has the opportunity to enhance the PIP Aim Statement by including the improvement strategy and associated timeframe. Additionally, MMM did not clearly define its measurement methodology or provide a comprehensive interpretation of the PIP data with analysis of interventions and lessons learned.
	EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
One clinical care project in the area of increasing fistula use for Enrollees at risk for dialysis.	Moderate Confidence: MMM's PIP demonstrates improvement overtime, however analysis for statistical significance in improvement was not identified.

Molina

1. General PIP Information
MCO Name: Molina
PIP Title: AVF Usage Improvement Initiative
PIP Aim Statement: Increase in AVF usage among CKD Stage 4/End Stage Renal Disease (ESRD) members at risk or in use of hemodialysis.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic).

☐ Collaborative (plans worked together during the planning or implementation phases).
☐ Statewide (the PIP was conducted by all MCOs and/or [PIHPs] within the State).
☐ Plan choice (State allowed the plan to identify the PIP topic).

Target age group (check one):
☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children
***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify):
Molina included two quality indicators, targeting the following populations:
1. All ESRD members 18 years or older on dialysis >90 days.
2. Stage 4 CKD (GFR<30) pre-dialysis members and ESRD Members.

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

Member outreach and engagement.

Assist members with transportation.

Assign members to level II Case Management.

Outreach to dialysis centers.

Engage Peripheral Vascular Surgeons.

Engage Social Workers at dialysis facilities.

Case Managers perform in-person engagement at dialysis centers.

Continuous data analysis.

In-person engagement due to communication barriers.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator #1: Increase AVF functional usage for ESRD members on dialysis.	CY 2016	50.4%	CY 2020 Q2	95%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Quality Indicator #2: Early referral to surgeon for "AVF only" evaluation and timely placement.	CY 2016	0.02%	CY 2020 Q2	95%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☒ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

MCO strengths:

Molina provided a comprehensive analysis and identification of opportunities for improvement with the PIP strategy and timeline of all interventions in the earlier years of the PIP.

Molina reported many factors impacting the PIP improvement including several natural disasters followed by the coronavirus disease 2019 (COVID-19) PHE, affecting provider access and communication services with implementation. Despite the impact, Molina was able to demonstrate improvement over time.

EQRO recommendations:

Although Molina clearly indicates the PIP focus, describes the framework for data collections and analysis, and defines the improvement strategy, population, and time period, there is not an Aim Statement identified. Recommend developing Aim Statements that are clear, concise, measurable, and answerable, setting the direction for achieving tangible results.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended Molina consider this opportunity to include measures that capture changes in Enrollee satisfaction or experience of care.

Molina provided their Quality Improvement Committee Health Care Services Program Description outlining general staffing roles, qualifications, and trainings. Molina's Case Management Department staff were responsible for the analysis and interventions with this PIP; however, data collection personnel and relevant qualifications are not outlined in the information provided. It is recommended Molina consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

Molina's PIP documents included an option to enter Statistical Test and Significance, however the statistical significance information was not included. Recommendation to perform and provide evidence of statistical testing of hypothesis and correlation to interventions.

Molina PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include appropriate cultural and linguistic approach with PIP process.

The information submitted for 2019 and 2020 provided a less descriptive analysis and identified areas for improvement, and a reduction in interventions compared to the earlier years. Recommendation to consistently provide data analysis on prescribed timeline for all interventions throughout the life of the PIP.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One clinical care project in the area of increasing fistula use for Enrollees at risk for dialysis.	Moderate Confidence: Molina provided a comprehensive description and well documented phases of design and data collection and conducted accurate data analysis and interpretation for multiple years with this PIP.

PIP	EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
One clinical care project in the area of increasing fistula use for Enrollees at risk for dialysis.	Moderate Confidence: Molina provided data supporting improvement, however analysis for statistical significance was not identified.

PSM

1. General PIP Information
MCO Name: PSM
PIP Title: AVF/Arteriovenous Grafts (AVGs) — PSM Fistula First Catheter Last Educational Program
PIP Aim Statement: This initiative aims to increase awareness and offer educational tools to all eligible PSM beneficiaries in advanced stages of CKD choosing hemodialysis to make informed decisions and optimize AVF as vascular access selection.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or prepaid inpatient health plans [PIHPs] within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): PSM beneficiaries with glomerular filtration rate (GFR)<30 (CKD Stage 4), GFR <15 (CKD Stage 5), or Patients on Hemodialysis

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

Identifying eligible Enrollees, providing education to members and family, and referrals for AVF placement.

Changing provider practice by reaching out to providers and providing educational materials on the benefits and management of AVF placement.

Identifying eligible Enrollees and making appropriate referrals.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator: Vascular Access History for patient who choose hemodialysis.	Baseline year not provided.	Data Not Provided.	CY 2022	92%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Unclear. Baseline year not provided

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

MCO strengths:

PSM demonstrated alignment with HHS and CMS priority areas, considering CMS child and adult core set measures when applicable and incorporated the use of a HEDIS certified vendor for metric calculations with adherence to NCQA's HEDIS Technical specifications.

PSM has a team-based approach, and it utilizes care managers and health education for Enrollee and provider education.

EQRO recommendations:

PSM clearly outlines the focus of the PIP, but the absence of a clearly defined Aim Statement is notable. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

Performance evaluation is crucial to identify successful interventions. The metric for this PIP indicates the utilization of AVF/AVGs, however numerator and denominators were not clearly defined. It is recommended PSM clearly defined the metric, providing technical specifications used for both numerator and denominator.

PSM PIP lacked a clearly defined baseline year or established period, hindering the accurate measurement of progress and effectiveness. It is recommended that PSM select a baseline year and a specified period for their PIP to ensure precise and meaningful analysis of the PIP's progress and outcomes.

PSM's data analysis of the PIP did not indicate the use of continuous QI techniques or integration of lessons learned, limiting opportunities for enhancement in future iterations of the PIPs.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended PSM perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended PSM consider this opportunity to include measures that capture changes in Enrollee satisfaction or experience of care.

PSM PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include appropriate cultural and linguistic approach with the PIP process.

Data collection personnel and qualifications were not included in the PIP. It is recommended that PSM consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One clinical care project in the area of increasing fistula use for Enrollees at risk for dialysis.	Low Confidence: PSM's PIP Aim Statement lacked specificity and measurability to set the direction for achieving tangible results. Baseline year and comparative assessment data were not clearly identified or defined and the PIP did not articulate the improvement strategy. PIP metrics and data collection procedures were not clearly defined, impacting reliability of data reported.

PIP	EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
One clinical care project in the area of increasing fistula use for Enrollees at risk for dialysis.	Low Confidence: The PIP did not include a clearly defined metric, baseline year, or time period for PIP data, preventing interpretation of improvement.

Triple S

1. General PIP Information
MCO Name: Triple S
PIP Title: Increase the Prevalence of Permanent Vascular Access Among Patient in Hemodialysis
PIP Aim Statement: Increase the prevalence of members with permanent vascular access who receives hemodialysis. Target goal will be 3% of qualified population graduated for the first year (2022), 5% for the second year (2023), and 7% for the third year (2024).
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): Members diagnosed with ESRD admitted to a hemodialysis unit with a catheter or any non-permanent access in place.
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

Re-evaluation of the documentation process into the CM documentation tool to be able to see all actions and efforts made by the CM staff.

Follow-Up with Data Analytics Department to see the status of documentation evaluation and population interventions to have a clear number of impacted members.

Meeting with local physician to evaluate barriers that were experienced with program.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator: Increase the prevalence of members with permanent venous access receiving dialysis.	Not Provided.	Not Provided.	CY 2022	1/347	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Baseline year not provided

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

MCO strengths:
Triple S' PIP described multiple member and provider engagement and follow-up interventions to improve AVF utilization.

Triple S performed extensive research, highlighting National Kidney Foundation guidelines, and accepted clinical practice guidelines for AVF use with best overall performance, fewer infections, longevity, and increased blood flow resulting in a more adequate dialysis treatment.

EQRO recommendations:
Triple S' PIP did not define the baseline year or demonstrate a defined data collection procedure and measurement methodology to analyze results accurately and develop appropriate interventions. Additionally, the data analysis for the PIP did not incorporate continuous QI techniques or effectively incorporate lessons learned. It is recommended the PIP identify its baseline year and data collection methods as well as adopt and implement continuous QI methodologies such as PDSA or rapid cycle approaches and incorporating lessons learned to identify areas of opportunity within the PIP.

Triple S' Aim Statement lacked specificity and measurability, necessary for setting clear, actionable goals. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended Triple S perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended Triple S consider this opportunity to include measures that capture Enrollee satisfaction or experience of care.

Triple S PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include an appropriate cultural and linguistic approach with the PIP process.

Data collection personnel qualifications were not clearly indicated in the PIP. It is recommended that Triple S consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One clinical care project in the area of increasing fistula use for Enrollees at risk for dialysis.	Moderate Confidence: Triple S provided a comprehensive description and adhered to most phases of the protocol. However, the PIP did not distinctly identify the baseline year or the data collection procedure and measurement methodology to accurately analyze results. Triple S has the opportunity

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
	to enhance the PIP Aim Statement by clearly defining the improvement strategy, target population, and measurable impact. Additionally, the PIP analysis did not clearly state the interpretation of the data or analysis of interventions.
PIP	**EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement**
One clinical care project in the area of increasing fistula use for Enrollees at risk for dialysis.	Low Confidence: The PIP did not distinctly define the baseline year or time period for PIP data, preventing interpretation of improvement.

Topic 2: One Clinical Care Project in the Area of BH

FMHP

1. General PIP Information
MCO Name: FMHP
PIP Title: Reduction in Readmission Rate for Patients with BH Diagnosis
PIP Aim Statement: Aim to reduce the readmission rate within 30 days of discharge for patients with a mental health (MH) condition.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): GHP patients who have a principal MH diagnosis and who were discharged from an acute inpatient setting.
Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions

Monitor Enrollee needs for assistance and additional service via telephonic contact at least every three months.

Referral to other health organizations and/or community resources when appropriate and ensure closed-loop referral.

Provider outreach: Educational newsletter on the importance of post-discharge appointments to prevent readmission and ensure patient treatment adherence.

Referrals to the Case Management Program for Enrollees who experienced psychiatric readmissions to receive support in navigating the healthcare system and preventing readmission.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator: Percentage of readmissions within 30 days for BH diagnosis.	CY 2018	14.6%	CY 2022 Quarter 4	15.6%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Third re-measurement

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

MCO strengths:

FMHP's interventions incorporated a range of strategies to engage Enrollees and Providers as well as identified internal best practices for CM engagement to enhance QOC.

Despite challenges from a PHE affecting provider access to Enrollees and providing services, FMHP pivoted and implemented strategies to continue engagement with Enrollees and Providers.

EQRO recommendations:

FMHP's PIP Aim Statements currently lack specificity and measurability, crucial for setting clear, actionable goals. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

FMHP's data analysis for the PIP did not demonstrate continuous QI techniques or effectively incorporate lessons learned. To enhance the effectiveness of FMHP's PIPs, it is recommended to adopt and implement continuous QI methodologies. These methodologies, such as PDSA or rapid cycle approaches, are crucial for incorporating lessons learned and identifying areas of opportunity within the PIP. Integrating these techniques will significantly improve the overall quality and outcomes of FMHP's PIPs.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended FMHP perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended FMHP consider this opportunity to include measures that capture Enrollee satisfaction or experience of care.

FMHP PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include an appropriate cultural and linguistic approach with the PIP process.

Data collection personnel qualifications were not clearly indicated in the PIP. It is recommended that FMHP consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One clinical care project in the area of BH.	Moderate Confidence: FMHP provided a comprehensive description and adhered to most phases of the protocol. FMHP has the opportunity to enhance the PIP aim statement by clearly defining the target population and measurable impact. The PIP analysis did not clearly state the interpretation of the data and there was a noticeable gap in analysis of the interventions.
PIP	**EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement**
One clinical care project in the area of BH.	Low Confidence: FMHP's PIP data did not show consistent improvement over the years.

MMM

1. General PIP Information
MCO Name: MMM
PIP Title: BH Performance Improvement Project — Opioid utilization
PIP Aim Statement: To decrease in 5% the percentage of members 18 years and older with a new episode of opioid use, in a three-year period. To increase in 5% the percentage of beneficiaries of MMM with diagnosis of opioid dependence who receive services from a BH provider in a three-year period. To decrease in 5% the concurrent use of opioids and benzodiazepines (COB) among beneficiaries of MMM in a three-year period.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): Medicaid members 18 years old and above diagnosis with opioid dependence.
Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions

Face-to-face orientations for PCPs, to raise awareness about the opioid epidemic and misuse, Centers for Disease Control and Prevention (CDC) Opioid Prescription Guidelines, alternatives of treatment, and tapering.

Education article published in the Provider Bulletin.

Monthly face-to-face intervention with top Prescribers.

Opioid Program educational materials.

Opioid Prescribing Guideline Application for smart phones.

Infographic — Safe Alternatives for Pain Management.

Advisory Board presentation — To raise awareness and promote opioid prescription guidelines.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator #1: HEDIS COU measure — Continued Opioid Use (COU); Percentage of members 18 years and older who have a new episode of opioid use with at least 31 days of prescription opioids in a 62-day period.	CY 2018	9.02%	CY 2021	1.4%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Quality Indicator #2: Pharmacy Quality Alliance (PQA) COB measure — COB (NQF #3389);	CY 2018	3.8%	CY 2021	16.14%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05

Percentage of individuals ≥18 years with concurrent use of prescription opioids and benzodiazepines for ≥30 cumulative days.						Other (specify): Not analyzed for statistical significance
Quality Indicator #3: Percentage of members with a diagnosis of opioid abuse or dependence are receiving BH treatment.	CY 2018	42.5%	CY 2021	40.2%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Third re-measurement

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

MCO strengths:

MMM engaged MH and Pharmacy Department management staff for the development of the PIP, focusing on collaboration. MMM also held meetings to gather recommendations, validate existing strategies, and solicit input to enhance the PIP.

MMM demonstrated alignment with the priority areas of HHS and CMS by incorporating Core set, HEDIS, and PQA measures.

MMM conducted thorough searches on the topic prior to selecting it for the PIP. They referenced sources such as the Puerto Rico Health Science Journal, highlighting the rise of the issue in Puerto Rico, and utilized information from the National Institute on Drug Abuse and the American Society of Addiction Medicine to demonstrate the need for the chosen PIP topic.

MMM used a HEDIS-certified vendor, overseen by the NCQA, for the calculation of its metrics.

EQRO recommendations:

The Aim Statement and study question of MMM lack specificity in how the goals will be achieved. It is recommended for MMM to develop Aim Statements that are clear, concise, measurable, and answerable, thereby ensuring that they encompass a clear improvement strategy and set the direction for achieving tangible results.

MMM's data analysis for the PIP did not demonstrate continuous QI techniques or effectively incorporate lessons learned. To enhance the effectiveness of MMM's PIPs, it is recommended to adopt and implement continuous QI methodologies. These methodologies, such as PDSA or rapid cycle approaches, are crucial for incorporating lessons learned and identifying areas of opportunity within the PIP. Integrating these techniques will significantly improve the overall quality and outcomes of MMM's PIPs.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended MMM perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended MMM consider this opportunity to include measures that capture Enrollee satisfaction or experience of care.

MMM PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include an appropriate cultural and linguistic approach with the PIP process.

Data collection personnel qualifications were not clearly indicated in the PIP. It is recommended that MMM consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One clinical care project in the area of BH.	Moderate Confidence: MMM provide a comprehensive description and adhered to most phases of the protocol. MMM has the opportunity to enhance the PIP Aim Statement by including the improvement strategy. MMM did not clearly define its measurement methodology or provide a comprehensive interpretation of the PIP data with analysis of interventions and lessons learned.

PIP	EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
One clinical care project in the area of BH.	Moderate Confidence: MMM's PIP data from 2018 onward indicates improvement in one of the metrics. Improvement was observed in another measure during 2019 and 2020 but was not maintained in the final measurement period. Analysis for statistical significance in improvement was not identified.

Molina

1. General PIP Information
MCO Name: Molina
PIP Title: Improvement in BH Inpatient to Outpatient Transitions of Care
PIP Aim Statement: Ensure members six years of age and older, being discharged from a psychiatric inpatient facility and, referred to an outpatient level of care, are being seen by a MH practitioner within seven days of discharge; or in the event that the follow-up appointment is not kept within seven days, the member is seen by a MH practitioner within 30 days of discharge.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): Medicaid members six years of age and older who were discharged from an acute inpatient setting with principal diagnosis of mental illness.
Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
2. Improvement Strategies or Interventions
On-site or telephonic discharge planning. Assist with appointment scheduling.

Transition coach conduct face-to-face and/or phone contacts post discharge.

Outreach and health fairs.

Validate discharge list daily.

Obtain discharge summaries.

Deploy transition coaches.

Discharge planning.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator 1: HEDIS FUH measure — Follow-Up After Hospitalization for Mental Illness — 30 days; Percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness and who received a follow-up outpatient visit, an intensive outpatient encounter or partial hospitalization with a MH practitioner within 30 days of discharge.	CY 2017	52.39%	CY 2020 Q2	53%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Quality Indicator 2: HEDIS FUH measure — Follow-Up After Hospitalization for Mental Illness — seven days; Percentage of discharges for members six years of age and older who were hospitalized for	CY 2017	35.08%	CY 2020 Q2	40%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

treatment of selected mental illness and who received a follow-up outpatient visit, an intensive outpatient encounter or partial hospitalization with a MH practitioner within seven days of discharge.						

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☒ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

MCO strengths:

Molina provided PIP research pointing to evidence for readmission reduction can include improving discharge planning and transition processes, better medication practices, enriching transitions and care coordination between care settings, and promoting the recovery-oriented practice model.

Molina presented a comprehensive analysis and identification of opportunities for improvement with the PIP strategy and timeline of all interventions.

Molina reported many factors impacting the PIP improvement including several natural disasters followed by the COVID-19 PHE, affecting provider access and communication services with implementation. Despite the impact, Molina was able to demonstrate improvement over time.

Molina provided their Quality Improvement Committee Health Care Services Program Description outlining general staffing roles, qualifications, and trainings. Molina indicated all processes involved during the HEDIS data collection and medical records abstraction are based on the HEDIS

specifications and are audited during the HEDIS Compliance Audit. Molina Healthcare uses NCQA-certified software to report HEDIS rates. Molina indicated in the documents that HEDIS program managers have years of experience reporting HEDIS rates.

EQRO recommendations:
Although Molina clearly indicates the PIP focus, describes the framework for data collections and analysis, and defines the improvement strategy, population, and time period, there is not an Aim Statement identified. Recommend developing Aim Statements that are clear, concise, measurable, and answerable, setting the direction for achieving tangible results.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended Molina consider this opportunity to include measures that capture changes in Enrollee satisfaction or experience of care.

Molina's PIP documents included an option to enter Statistical Test and Significance, however the statistical significance information was not included. Recommendation to perform and provide evidence of statistical testing of hypothesis and correlation to interventions.

Molina PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include appropriate cultural and linguistic approach with PIP process.

Molina included several member-focused interventions; However, provider specific interventions are not clearly identified. It is recommended Molina consider this opportunity to research and develop additional provider-focused interventions for follow-up care.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One clinical care project in the area of BH.	Moderate Confidence: Molina provided a comprehensive description and well documented phases of design and data collection and conducted accurate data analysis and interpretation for multiple years with this PIP.

PIP	EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
One clinical care project in the area of BH.	Moderate Confidence: Molina provided data supporting improvement, however analysis for statistical significance was not identified.

PSM

1. General PIP Information

MCO Name: PSM

PIP Title: Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications

PIP Aim Statement: To identify adult members with Schizophrenia or Bipolar Disorder who were dispensed an antipsychotic and had a diabetes screening test during the MY. Members diagnosed with Schizophrenia or Bipolar Disorder who are taking Antipsychotic Medications should be screened for diabetes annually.

Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply):

☒ State-mandated (State required plans to conduct a PIP on this specific topic).
☐ Collaborative (plans worked together during the planning or implementation phases).
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State).
☐ Plan choice (State allowed the plan to identify the PIP topic).

Target age group (check one):

☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children

***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify):

Members diagnosed with Schizophrenia or Bipolar Disorder.

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

APS clinic began an educational intervention for Enrollees to understand the importance of being tested while on antipsychotic medicine.

Educate providers on the importance of testing and monitoring Enrollees with schizophrenia and bipolar diagnoses taking antipsychotic medication at risk of developing diabetes.

APS clinic performed a change in the system so the laboratory referrals could be sent directly to the Enrollees' preferred laboratory to ensure that Enrollees could get their lab done outside of the APS clinics in a timely manner.

3. PMs and Results						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Quality Indicator: NCQA HEDIS Measure SSD. This measure is defined as: The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the MY.	CY 2019	57.7%	CY 2022	66.49%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Third re-measurement year

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

MCO strengths:
Aligning with nationally recognized metrics, PSM incorporated the use of a HEDIS certified vendor for metric calculations and adhered to NCQA's HEDIS Technical specifications for this PIP's measure.

PSM has a team-based approach, and it utilizes care managers and health education to engage and perform outreach to Enrollees.

PSM reported several factors impacting the PIP improvement including several natural disasters followed by a PHE affecting provider access to Enrollees and the implementation of services. Despite these challenges, PSM effectively demonstrated ongoing improvement in their PIP.

EQRO recommendations:
PSM clearly outlines the focus of the PIP, but the absence of a clearly defined Aim Statement is notable. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

PSM's data analysis of the PIP did not indicate the use of continuous QI techniques or integration of lessons learned, limiting opportunities for enhancement in future iterations of the PIPs.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended PSM perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended PSM consider this opportunity to include measures that capture changes in Enrollee satisfaction or experience of care.

PSM PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include appropriate cultural and linguistic approach with the PIP process.

Data collection personnel and qualifications were not included in the PIP. It is recommended that PSM consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One clinical care project in the area of BH.	Moderate Confidence: PSM provided a comprehensive description and adhered to most phases of the protocol. PSM has the opportunity to enhance the PIP Aim Statement by clearly defining the

	improvement strategy, target population, measurable impact, and time period. The PIP analysis did not clearly state the interpretation of the data or analysis of interventions.
PIP	**EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement**
One clinical care project in the area of BH.	Moderate Confidence: PSM provided data supporting improvement, however the analysis and relation to successful improvement strategy was not clearly stated and inclusion of evaluation of statistical significance in improvement was not identified.

Triple S

1. General PIP Information
MCO Name: Triple S
PIP Title: Adult Body Mass Index — Intervention by a Nutritionist in Patients who had an Outpatient Visit to the APS clinics and have a body mass index (BMI) of 40 or greater
PIP Aim Statement: Careful monitoring of BMI will help healthcare providers identify adults who are at risk and provide focused advice and services to help them reach and maintain a healthier weight. Secondly, the intervention of a nutritionist helps the patient to improve eating styles and therefore decrease the BMI value and increase health outcomes.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): Patients identified with BMI of 30 or greater which did not receive a nutritional intervention.
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

Educational intervention with providers.

Face-to-face interventions with patients.

Nutritionist recruitment in Triple S.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator #1: Percentage of Patients served with a BMI Screening tool.	CY 2020 however not clearly articulated.	47.5%	CY 2022 Quarter 4	71.8%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Quality Indicator #2: Percentage of Patients with BMI of 40 or greater who have received an intervention by a nutritionist.	Not Provided.	Not Provided.	CY 2022 (August)	1.10%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☒ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

MCO strengths:

Triple S' PIP interventions successfully incorporated a range of strategies to enhance BMI monitoring and QOC.

Triple S performed research, highlighting recent studies and indications for best practices to monitor and treat obesity.

EQRO recommendations:

Triple S' Aim Statement lacked specificity and measurability, necessary for setting clear, actionable goals. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

For Triple S to effectively measure progress and outcomes, it is crucial to clearly articulate the baseline year and rate with each reporting cycle. This foundation is essential for accurate and meaningful analysis. It is recommended that Triple S identify the baseline year to ensure precise and meaningful analysis of the PIP's progress and outcomes.

Triple S' PIP data analysis did not incorporate continuous QI techniques or effectively incorporate lessons learned. It is recommended the PIP identify its data collection methods as well as adopt and implement continuous QI methodologies such as PDSA or rapid cycle approaches and incorporating lessons learned to identify areas of opportunity within the PIP.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended Triple S perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended Triple S consider this opportunity to include measures that capture Enrollee satisfaction or experience of care.

Triple S PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include an appropriate cultural and linguistic approach with the PIP process.

Data collection personnel qualifications were not clearly indicated in the PIP. It is recommended that Triple S consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One clinical care project in the area of BH.	Moderate Confidence: Triple S provided a comprehensive description and adhered to most phases of the protocol. Triple S has the opportunity to enhance the PIP Aim Statement by clearly defining the improvement strategy, target population, and measurable impact. The PIP did not clearly articulate the baseline year or the data collection procedure and measurement methodology to accurately analyze results. Additionally, the PIP analysis did not clearly state the interpretation of the data or analysis of interventions.
PIP	
One clinical care project in the area of BH.	Moderate Confidence: Triple S provided data supporting improvement, however analysis for statistical significance in improvement was not identified.

Topic 3: One Administrative Project in the Area of EPSDT

FMHP

1. General PIP Information
MCO Name: FMHP
PIP Title: EPSDT
PIP Aim Statement: The Aim Statement was not provided.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): Medicaid-eligible children less than 21 years of age.
Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions

Implementation of alerts for gaps in EPSDT visits to members via automated phone calls.

Outreach to parents/guardians for persistent gaps in EPSDT visits by an exclusively assigned staff.

Training orientations for parents/guardians about EPSDT.

Engage and assist PCPs with tracking their patient's adherence to EPSDT preventive tests.

Maintain a comprehensive EPSDT Program Education and Training for Providers and Social Workers.

Education trainings by Care Managers as part of OB-GYN Subgroup on the importance of EPSDT services.

Send EPSDT orientation letters to new eligible members.

Provide EPSDT Continuing Education for Physicians.

Quality Circle (sessions) to discuss non-compliance cases, intervention results, root causes, and further interventions.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator: Ensure that Medicaid-eligible children less than 21 years of age are screened and treated in timely manner.	Not provided.	Not provided.	CY 2022	EPSDT Report 416 provided with numerous metrics not specified in the PIP.	☐ Yes ☐ No ☒ Unknown	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year
☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Sixth re-measurement

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

MCO strengths:

The FMHP PIP included detailed information on root cause analyses, action/work plans, and distributed materials to members or providers, such as practice guidelines, newsletters, educational materials, and provider report cards.

FMHP PIP implemented extensive outreach to ensure Enrollees were updated with EPSDT services, including automated alerts, frequent calls from dedicated staff to members' parents/guardians, and provided EPSDT orientations at all service offices.

FMHP PIP carried out extensive outreach to ensure providers and care teams were engaged, including efforts to involve PCPs in monitoring their patients' adherence to EPSDT preventive tests, maintaining a comprehensive EPSDT Program Education and Training for Providers and Social Workers, and providing ongoing EPSDT education for physicians.

EQRO recommendations:

FMHP PIP lacked a clearly defined baseline year and specified metrics, hindering the accurate measurement of progress and effectiveness. It is recommended that FMHP select clearly defined metrics and establish a baseline year to ensure a precise and meaningful analysis of the PIP's progress and outcomes.

FMHP's PIP Aim Statements currently lack specificity and measurability, crucial for setting clear, actionable goals. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

FMHP's data analysis for the PIP did not demonstrate continuous QI techniques or effectively incorporate lessons learned. To enhance the effectiveness of FMHP's PIPs, it is recommended to adopt and implement continuous QI methodologies. These methodologies, such as PDSA or

rapid cycle approaches, are crucial for incorporating lessons learned and identifying areas of opportunity within the PIP. Integrating these techniques will significantly improve the overall quality and outcomes of FMHP's PIPs.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended FMHP perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended FMHP consider this opportunity to include measures that capture Enrollee satisfaction or experience of care.

FMHP PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include an appropriate cultural and linguistic approach with the PIP process.

Data collection personnel qualifications were not clearly indicated in the PIP. It is recommended that FMHP consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One administrative project in the area of EPSDT.	Low Confidence: FMHP's PIP Aim Statement lack specificity and measurability to set the direction for achieving tangible results. Baseline year was not identified and a concise improvement strategy was not provided. Additionally, PIP metrics and data collection procedures were not clearly defined, impacting reliability of data reported.
PIP	**EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement**
One administrative project in the area of EPSDT.	Low Confidence: The PIP lacked baseline data and limited information regarding the specific metrics and data sources, preventing interpretation of improvement.

MMM

1. General PIP Information
MCO Name: MMM
PIP Title: EPSDT Screening — Adolescent Well-Care (AWC)
PIP Aim Statement: To improve in 3% the rate of beneficiaries from 12 to 21 years of age who receive at least one comprehensive well-care visit during the year in a three-year period.

Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply):
☒ State-mandated (State required plans to conduct a PIP on this specific topic).
☐ Collaborative (plans worked together during the planning or implementation phases).
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State).
☐ Plan choice (State allowed the plan to identify the PIP topic).

Target age group (check one):
☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children
***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify):
Adolescent population from 12 to 21 years of age.

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions

Phone outreach by the EPSDT staff to educate parents of adolescents about the importance of well-care visits (WCV), preventive services, and provider availability (office location, business hours, etc.).

Coordinate with providers and their staff to arrange appointments for adolescents who did not visit their PCP during the year.

Letter for pediatricians and other PCPs explaining the project.

Created an educational module with continuing education credits available. The Module addresses the documentation, codification, and compliance of the preventive service guidelines.

Face-to-face visits with PCPs to educate providers and PMG's staff about this project.

Provide measure outcomes on a quarterly basis to PCPs and PMGs.

Advisory Board presentation — to educate providers and other PMG staff about this project, goals, and interventions.

Implementation of the Pediatric Annual Health Assessment (AHA) — This assessment allows the PCPs to submit an encounter for the AWC visit.

3. PMs and Results						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Quality Indicator #1: HEDIS AWC measure — Adolescent Well-Care; Percentage of adolescents 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the MY.	CY 2018	42.85%	CY 2021	34.36%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Third re-measurement

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

MCO strengths:

Despite challenges in transitioning the PIP metrics from AWC to WCV, there was a 7.4% rate increase from 2020 to 2021. MMM persisted in enhancing EPSDT screenings, focusing on adolescents with the lowest well-care rates.

MMM's PIP emphasized member and provider-focused interventions, using a comprehensive approach, including phone outreach to educate members and engagement strategies for providers designed to enhance the effectiveness of the plan.

MMM implemented a Pediatric AHA tool, allowing PCPs to submit encounters for adolescent well-care visits, ensuring comprehensive health assessments for this population.

MMM's selection of the PIP was informed by a thorough literature review that examined factual studies, best practices, and guidelines. This process allowed MMM to identify the precise area of opportunity.

Aligning with nationally recognized metrics, MMM incorporated the use of a HEDIS certified vendor for metric calculations and adhered to NCQA's HEDIS technical specifications for this PIP's measure.

EQRO recommendations:

MMM's PIP Aim Statements currently lack specificity and measurability, crucial for setting clear, actionable goals. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

MMM's data analysis for the PIP did not demonstrate continuous QI techniques or effectively incorporate lessons learned. To enhance the effectiveness of MMM's PIPs, it is recommended to adopt and implement continuous QI methodologies. These methodologies, such as PDSA or rapid cycle approaches, are crucial for incorporating lessons learned and identifying areas of opportunity within the PIP. Integrating these techniques will significantly improve the overall quality and outcomes of MMM's PIPs.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended MMM perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

MMM PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended MMM consider this opportunity to include measures that capture Enrollee satisfaction or experience of care.

MMM PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include an appropriate cultural and linguistic approach with the PIP process.

Data collection personnel qualifications were not clearly indicated in the PIP. It is recommended that MMM consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One administrative project in the area of EPSDT.	Moderate Confidence: MMM provide a comprehensive description and adhered to most phases of the protocol. MMM has the opportunity to enhance the PIP Aim Statement by including the improvement strategy. MMM did not clearly define its measurement methodology or provide a comprehensive interpretation of the PIP data, with analysis of interventions and lessons learned.

PIP	EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
One administrative project in the area of EPSDT.	Low: MMM's PIP data did not show consistent improvement over the years, however, it is worth noting that there is an observed rate increase between 2020 and 2021. Analysis for statistical significance in improvement was not identified.

Molina

1. General PIP Information
MCO Name: Molina
PIP Title: Improving EPSDT Screening Rates/Comprehensive Well-Care Visits
PIP Aim Statement: 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 of Age, Childhood Immunizations, Well-Child Visits in 3–6 Years of Age, and AWC Visits.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☒ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**: 15 months of age to 21 years of age
Target population description, such as duals, LTSS, or pregnant women (please specify): PIP targets the Well-Child Visit population from ages 15 months to 21 years.

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions

Member outbound calls for gaps in EPSDT services.

Member reminder mailings for scheduling visits.

CM Intervention with care plan development.

Member engagement with health educators.

Educational brochures.

Health Fairs.

Provider engagement visits, discussing performance.

Distribution of EPSDT provider toolkit.

EPSDT lists sent to providers monthly.

Gaps in care lists reviewed with providers quarterly.

Work directly with providers and staff on interventions to increase compliance with EPSDT visits.

Gaps in care lists.

EPSDT toolkit development.

HEDIS tips for providers.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value

Quality indicator #1: HEDIS CIS measure — Childhood Immunization Status — Combination 10; Percentage of children who received the recommended immunizations (4 DTaP, 3 IPV, 3 Hep B, 3 HiB, 1 MMR, 1 Varicella, 4 Pneumo, 1 Hep A, 2 or 3 Rotavirus, and 1 flu) on or before their second birthday.	CY 2016	15.50%	Fiscal year (FY) 2019 (June–July)	Removed	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Quality Indicator #2: HEDIS W15 measure — Well-Child Visits in the First 15 Months of Life — Six or more well visits; Children who received six or more well-child visits on different dates of service with a PCP during their first 15 months of life.	CY 2016	12%	FY 2019 (June–July)	10.89%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Quality Indicator #3: HEDIS W34 measure — Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Children 3–6 years of age who had one or more well-child visits with a PCP during the MY.	CY 2016	46.57%	FY 2019 (June–July)	20.22%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

Quality Indicator #4: HEDIS AWC — Adolescent Well-Care Visits; 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 MY.	CY 2016	33.6%	FY 2019 (June–July)	10.92%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☒ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

MCO strengths:

Molina included an evaluation of other Molina health plans, comparing percentile ratings to national ratings, identifying gaps to support improvement of the Puerto Rico EPSDT services. Molina estimated an impact from this PIP could improve outcomes for approximately 100,000 of their Puerto Rico members between the ages of 0–21 years.

Molina presented a comprehensive background for the need to improve Well-Child visits and immunizations, citing research articles supporting well childcare utilization improvement and the ability to identify development and behavior issues as well as an opportunity for providers to engage members for health promotion activities. Molina's PIP topic is clear and uses nationally recognized metrics for evaluation.

Molina provided their Quality Improvement Committee Health Care Services Program Description outlining general staffing roles, qualifications, and trainings. Molina indicated all processes involved during the HEDIS data collection and medical records abstraction are based on the HEDIS

specifications and are audited during the HEDIS Compliance Audit. Molina Healthcare uses NCQA-certified software to report HEDIS rates. Molina indicated in the documents that HEDIS program managers have years of experience reporting HEDIS rates.

Despite observing a decline in utilization outcomes, Molina presented a comprehensive approach to monitor outcomes and revise interventions to improve rates during several natural disasters and the COVID-19 PHE.

EQRO recommendations:
Although Molina clearly indicates the PIP focus, describes the framework for data collections and analysis, and defines the improvement strategy, population, and time period, there is not an Aim Statement identified. Recommend developing Aim Statements that are clear, concise, measurable, and answerable, setting the direction for achieving tangible results.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended Molina consider this opportunity to include measures that capture changes in Enrollee satisfaction or experience of care.

Molina's PIP documents included an option to enter Statistical Test and Significance, however the statistical significance information was not included. Recommendation to perform and provide evidence of statistical testing of hypothesis and correlation to interventions.

Molina PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include appropriate cultural and linguistic approach with PIP process.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One administrative project in the area of EPSDT screening.	Moderate Confidence: Molina provided a comprehensive description and well documented phases of design and data collection and conducted accurate data analysis and interpretation for multiple years with this PIP.

PIP	EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
One administrative project in the area of EPSDT screening.	Low Confidence: Molina reported a decline in PIP related utilization outcomes. Analysis for statistical significance was not identified.

PSM

1. General PIP Information
MCO Name: PSM
PIP Title: Improving Oral Access for Children under PSM Vital Program
PIP Aim Statement: To monitor the provision of screening, diagnosis, and treatment of oral health problems before they become permanent, lifelong disabilities.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): Medicaid and CHIP Enrollees between ages 2 and 20 years old.
Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
2. Improvement Strategies or Interventions
Educational intervention for Enrollees on importance of preventive dental visits. Provide gap in care reports to PCP and PSM care managers to follow-up with Enrollees. PSM Care Managers and health educators visited pediatricians to educate on the importance of preventive visits emphasizing oral health screening and referrals. Gaps in care reports to PCPs.

3. PMs and Results						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Quality Indicator: HEDIS Annual Dental Visit (ADV) measure — Percentage of members 2–20 years of age who had at least one dental visit during the MY.	CY 2019	Data Not Provided.	CY 2021	50.3%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☒ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

MCO strengths:

PSM demonstrates alignment with the priority areas of HHS and CMS, taking into account CMS' child and adult core set measures and oral health initiatives while complying with the Puerto Rico Law 63 requirements.

Aligning with nationally recognized metrics, PSM incorporated the use of a HEDIS certified vendor for metric calculations and adhered to NCQA's HEDIS Technical specifications for this PIP's measure.

PSM's team-based approach involved Care Managers and Health Educators visiting pediatricians to provide education on the importance of preventive visits, with a particular focus on oral health screening and referrals.

PSM reported several factors impacting the PIP improvement including several natural disasters followed by a PHE affecting provider access to Enrollees and the implementation of services. Despite these challenges, PSM effectively demonstrated ongoing improvement in their PIP.

EQRO recommendations:

PSM clearly outlines the focus of the PIP, but the absence of a clearly defined Aim Statement is notable. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

PSM's data analysis of the PIP did not indicate the use of continuous QI techniques or integration of lessons learned, limiting opportunities for enhancement in future iterations of the PIPs.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended PSM perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended PSM consider this opportunity to include measures that capture changes in Enrollee satisfaction or experience of care.

PSM PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include appropriate cultural and linguistic approach with the PIP process.

Data collection personnel and qualifications were not included in the PIP. It is recommended that PSM consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One administrative project in the area of EPSDT.	Moderate Confidence: PSM provided a comprehensive description and adhered to most phases of the protocol. PSM has the opportunity to enhance the PIP AIM Statement by clearly outlining the improvement strategy, target population, measurable impact, and time period. Although the data was evaluated quarterly, the PIP does not describe use of PDSA cycle, applying rapid cycle learning principles and adjusting intervention strategies as indicated.

PIP	EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
One administrative project in the area of EPSDT.	Low Confidence: PSM provided data supporting improvement from CY 2020 to CY 2021, however the baseline data was not observed impacting analysis of improvement. Inclusion of evaluation of statistical significance in improvement was also not identified.

Triple S

1. General PIP Information
MCO Name: Triple S
PIP Title: EPSDT PIP W-34
PIP Aim Statement: Aim Statement is not clearly articulated.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☒ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☐ Both adults and children: ***If PIP uses different age threshold for children, specify age range here**: Members between 3–6 years old
Target population description, such as duals, LTSS, or pregnant women (please specify): Percentage of members from 3–6 years of age in receipt of Medicaid who had one or more Well-Child visits with a PCP during the MY of eligible population.
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
2. Improvement Strategies or Interventions

Telephone outreach and education with PCPs regarding EPSDT well-child visit requirements and preventive visits appointment coordination.

Outreach staff provide reminder notifications to the members with well-child visits appointment coordination and follow-up.

Outreach staff followed up with members requiring further medical services identified in the well-child visits until the condition is corrected or ameliorated.

Include Well-Child Visit related topics in the Continued Medical Education activities focus on screening required by age and codification.

Orientation to Super PMGs Administrators about the importance of the well-child visits.

Developed activities in conjunction with Super PMGs to impact the pediatric population and coordinate the well-child visits required.

Required initial health risk assessments (HRAs) to identify members under children and youth with special healthcare needs (CYSHCN) and Autism conditions category.

Provided virtual educational modules to reinforce education about the EPSDT Program, offering special emphasis in preventive and evidence base practices, services guidelines, as well as EPSDT Contract requirements, billing codes and provider responsibilities.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator #1: HEDIS W34 measure — Well-Child Visits in the Third, Fourth, and Sixth years of Life; Percentage of members 3–6 years of age who had one or more well-child visit with a PCP during the MY.	CY 2020	31%	CY 2022	49.99%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Quality Indicator #2: Outreach 60% of the total	CY 2020 however not	Not Provided.	CY 2022	50%	☐ Yes	☐ Yes ☐ No

pediatric population of the ages of 3–6 years old included in the study.	clearly articulated.				☒ No	Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Quality Indicator #3: Reach 100% of the pediatric population of the ages of 3–6 years old under each CYSHCN, and Autism category from the Health Care Improvement Program in 12 months' study period.	CY 2020 however not clearly articulated.	Not Provided.	Not Provided.	100%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Quality Indicator #4: Recruit 30% of the reached members with specific conditions (CYSHCN and Autism) under the CM program.	CY 2020 however not clearly articulated.	Not Provided.	Not Provided.	99.9%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Quality Indicator #5: 100% completion initial HRA to eligible members of the recruited with specific conditions	CY 2020 however not clearly articulated.	Not Provided.	Not Provided.	100%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Quality Indicator #6: 100% completion annual HRA to eligible members of the Recruited with specific conditions	CY 2020 however not clearly articulated.	Not Provided.	Not Provided.	100%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

“Validated” means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):
☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year
☒ First re-measurement ☐ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO’s overall confidence that the PIP produced significant evidence of improvement.
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

MCO strengths:

The Triple S PIP focused on educational outreach for members and providers, highlighted by a virtual event, "Peques SSSaludables," educating participants on children's health prevention and good oral health practices.

Aligning with nationally recognized metrics, Triple S incorporated the use of HEDIS metric calculations, adhering to NCQA's HEDIS technical specifications for this PIP’s measure.

EQRO recommendations:

Triple S’ Aim Statement lacked specificity and measurability, necessary for setting clear, actionable goals. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

For Triple S to effectively measure progress and outcomes, it is crucial to clearly identify the baseline year and rate with each reporting cycle for each metric within the PIP structure. This foundation is essential for accurate and meaningful analysis. It is recommended that Triple S clearly identify the baseline year with rate for each metric to ensure precise and meaningful analysis of the PIP’s progress and outcomes.

Triple S’ PIP data analysis did not incorporate continuous QI techniques or effectively incorporate lessons learned. It is recommended the PIP identify its data collection methods as well as adopt and implement continuous QI methodologies such as PDSA or rapid cycle approaches and incorporating lessons learned to identify areas of opportunity within the PIP.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended Triple S perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended Triple S consider this opportunity to include measures that capture Enrollee satisfaction or experience of care.

Triple S PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include an appropriate cultural and linguistic approach with the PIP process.

Data collection personnel qualifications were not clearly indicated in the PIP. It is recommended that Triple S consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One administrative project in the area of EPSDT.	Moderate Confidence: Triple S provided a comprehensive description and adhered to most phases of the protocol. Triple S has the opportunity to develop a PIP Aim Statement by clearly defining the improvement strategy, target population, and measurable impact. Triple S provided a PIP that utilized HEDIS measures, indicating the development of a query fulfilling NCQA technical specifications; however, the documentation provided lacked details regarding data collection requirements for the remaining metrics. Additionally, the PIP analysis did not clearly state the interpretation of the data or analysis of interventions.
PIP	**EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement**
One administrative project in the area of EPSDT.	Moderate Confidence: Triple S provided data supporting improvement with Well-Child Visits, however analysis for statistical significance in improvement was not identified. Additionally, data provided for the other targeted goals did not consistently identify baseline year or re-measurement periods for data collection.

Topic 4: One Administrative Project in the Area of Co-location and Reverse Co-location of PH and BH, and Their Integration

FMHP

1. General PIP Information
MCO Name: FMHP
PIP Title: Improve Communication with Behavioral Provider and PCP in Collocation

PIP Aim Statement: To support the PCP in identifying and treating patients with MH diagnosis and/or needs for behavioral interventions. By February 2022, 20% or more of patients who receive co-location services in a Primary Care Group has a case discussion.

Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply):
☒ State-mandated (State required plans to conduct a PIP on this specific topic).
☐ Collaborative (plans worked together during the planning or implementation phases).
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State.).
☐ Plan choice (State allowed the plan to identify the PIP topic).

Target age group (check one):
☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☐ Both adults and children ☒ Other: Target age group not identified
***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify): Address Enrollees who mostly are healthy, have mild to moderate symptoms, and behaviorally influenced problems. The Medicaid members need to receive co-location services in a Primary Care Group.

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

Deliver provider education interventions regarding the importance of the Integrated Care Model: better communication and case discussion between professionals.

Monitor education data collection.

Perform quality intervention evaluations.

Incorporate Evidence-Based Clinical Guidelines for specific diagnoses commonly evaluated at a PMG.

Monitor access to collocated services within the PMG Collocation through quarterly utilization reports analysis.

Review results with the audited provider and/or PMG; established corrective actions if applicable based on findings.

3. PMs and Results						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Quality Indicator: Improve Communication between BH Providers and PCPs in Co-location Model.	CY 2014–2015	3.25%	CY 2022	27.1%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Seventh re-measurement

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

MCO strengths:

FMHP PIP concentrated on interventions for provider education, emphasizing the significance of the Integrated Care Model, which encompasses enhanced communication and more in-depth case discussions among professionals.

FMHP PIP is in alignment with PRMP goals and supported by the Puerto Rico Administración de Servicios de Salud Mental y Contra la Addicción/Mental Service Administration Health and Addiction.

Despite challenges such as PHEs affecting provider access to Enrollees and a decrease in the face-to-face interaction between BH and PCPs, FMHP pivoted and adjusted the implemented strategies to improve outcomes with the PIP.

EQRO recommendations:

FMHP's PIP Aim Statements currently lack specificity and measurability, crucial for setting clear, actionable goals. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

FMHP's data analysis for the PIP did not demonstrate continuous QI techniques or effectively incorporate lessons learned. To enhance the effectiveness of FMHP's PIPs, it is recommended to adopt and implement continuous QI methodologies. These methodologies, such as PDSA or rapid cycle approaches, are crucial for incorporating lessons learned and identifying areas of opportunity within the PIP. Integrating these techniques will significantly improve the overall quality and outcomes of FMHP's PIPs.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended FMHP perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended FMHP consider this opportunity to include measures that capture Enrollee satisfaction or experience of care.

FMHP PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include an appropriate cultural and linguistic approach with the PIP process.

Data collection personnel qualifications were not clearly indicated in the PIP. It is recommended that FMHP consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One administrative project in the area of co-location and reverse co-location of PH and BH, and their integration.	Moderate Confidence: FMHP provided a comprehensive description and adhered to most phases of the protocol. FMHP has the opportunity to enhance the PIP Aim Statement by clearly defining the improvement strategy, target population, measurable impact, and time period. The PIP analysis did not clearly state the interpretation of the data or analysis of interventions.

PIP	EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
One administrative project in the area of co-location and reverse co-location of PH and BH, and their integration.	Moderate Confidence: FMHP provided data supporting improvement, however exhibited varied performance over the years. The analysis and relation to successful improvement strategy was not clearly stated and inclusion of evaluation of statistical significance in improvement was not identified.

MMM

1. General PIP Information
MCO Name: MMM
PIP Title: Integration of MH and PH
PIP Aim Statement: To increase in 5% the Adults' Access to Preventive and Ambulatory Health Services metric rate among members with Serious Mental Illness (SMI) during a three-year period. To increase in 5% the case discussion between the PH provider and the MH provider, in a three-year period.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): Beneficiaries 20 years old or older, diagnosed with SMI and who received services from a co-located provider.
Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions

Training focused on integration, case discussion, and preventive services.

Touchpoints with MH Clinic administration/directors.

Educational bulletins for providers

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator #1: Percentage of members 20 years and older with a diagnosis of SMI who had an ambulatory or preventive care visit, during the MY.	CY 2018	20.1%;	CY 2021	90.2%;	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):Not analyzed for statistical significance
Quality Indicator #2: Percentage of case discussion (CPT 99368, 99367) services submitted to the health plan for beneficiaries who received services with the collocated provider during the MY.	CY 2018	0.90%	CY 2021	16.64%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Third re-measurement.

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

MCO strengths:
MMM's PIP provided robust provider-focused interventions, including training aimed at enhancing provider knowledge in areas such as integration, case discussions, and preventive services.

MMM conducted a comprehensive literature review, evaluating factual studies, best practices, and guidelines, in addition to analyzing available data. This process allowed MMM to identify the precise area of opportunity.

EQRO recommendations:
MMM's PIP Aim Statements currently lack specificity and measurability, crucial for setting clear, actionable goals. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

MMM's data analysis for the PIP did not demonstrate continuous QI techniques or effectively incorporate lessons learned. To enhance the effectiveness of MMM's PIPs, it is recommended to adopt and implement continuous QI methodologies. These methodologies, such as PDSA or rapid cycle approaches, are crucial for incorporating lessons learned and identifying areas of opportunity within the PIP. Integrating these techniques will significantly improve the overall quality and outcomes of MMM's PIPs.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended MMM perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended MMM consider this opportunity to include measures that capture Enrollee satisfaction or experience of care.

MMM PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include an appropriate cultural and linguistic approach with the PIP process.

Data collection personnel qualifications were not clearly indicated in the PIP. It is recommended that MMM consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One administrative project in the area of co-location and reverse co-location of PH and BH, and their integration.	Moderate Confidence: MMM provide a comprehensive description and adhered to most phases of the protocol. MMM has the opportunity to enhance the PIP Aim Statement by including the improvement strategy. MMM did not clearly define its measurement methodology or provide a comprehensive interpretation of the PIP data, with analysis of interventions and lessons learned.

PIP	EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
One administrative project in the area of co-location and reverse co-location of PH and BH, and their integration.	Moderate Confidence: MMM's PIP demonstrates notable improvement overtime, however, analysis for statistical significance in improvement was not identified

Molina (CY 2015–2018)

1. General PIP Information
MCO Name: Molina
PIP Title: PCP and BH Collaborative Care Project (CY 2015–2018)
PIP Aim Statement: 2015–2018 PIP: Improve participants scoring 50% or greater improvement in baseline depression scores at 12 months and achieve a 1% decrease in total cost of care (including program costs) compared to cost of care as usual after 12 months, for those individuals diagnosed with both depression and diabetes and enrolled in the Molina Healthcare's Collaborative Care Pilot Project.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify):

2015–2018 PIP: Members with confirmed diabetic diagnosis with member and PCP and physical evidence of PHQ-9 administration with obtained score by the member.

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

Member engagement.

Provider engagement.

Identifying depression diagnoses with individuals diagnosed with diabetes.

Receive lists of diabetic membership from PMGs.

Use alternative avenues for member contact.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator 1: Improve participants scoring 50% or greater improvement in baseline depression scores.	Not Reported.	Not Reported.	July 2017–June 2018	63.5%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Quality Indicator 2: 1% decrease in total cost of care.	Not Reported.	Not Reported.	July 2017–June 2018	2.64%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):
☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year
☐ First re-measurement ☒ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

MCO strengths:
Molina implemented the project with a comprehensive description and well documented phases of design and data collection.

Despite this being a mandated PIP, Molina provided a comprehensive set of supporting data and statistics for improved outcomes and impact with effective integration of behavioral healthcare with medical care.

EQRO recommendations:
Although Molina clearly indicates the PIP focus, describes the framework for data collections and analysis, and defines the improvement strategy, population, and time period, there is not an Aim Statement identified. Recommend developing Aim Statements that are clear, concise, measurable, and answerable, setting the direction for achieving tangible results.

Member and Provider engagement were listed as the main interventions. It is not clear from the documentation what was included in the information, education, or training to improve member outcomes and reduce the cost of care. Recommendation to include clear description of interventions.

Baseline data is provided in analysis; however, it is unclear what the baseline data represents. Recommendation to include description of baseline data and clearly identify time period for all reported data.

It is unclear if Molina identified the gaps in existing measures. Recommendation to evaluate appropriateness of measures and consider new measures when experiencing data reporting inaccuracies.

Molina included data methodology and sources and indicated outpatient medical/treatment record abstraction was utilized as a data source as well as a programmed pull from claims/encounters. It is not clear what the technical specifications were for the programmed pull or what was

calculated from the record abstraction. Recommendation to clearly describe technical specifications for data pulls, and outline record abstraction specifications as well as relevant review tool and scoring methodology for record review.

Molina indicated medical records were reviewed, however, it was not clear that IRR was implemented. Recommendation to clearly articulate IRR performance with medical record reviews (MRR).

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended Molina consider this opportunity to include measures that capture changes in Enrollee satisfaction or experience of care.

Molina's PIP documents included an option to enter Statistical Test and Significance, however the statistical significance information was not included. Recommendation to perform and provide evidence of statistical testing of hypothesis and correlation to interventions.

Molina PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include appropriate cultural and linguistic approach with PIP process.

Molina provided data rates and qualitative analysis outlining the outcomes; however, the documentation provided did not clearly indicate improvement strategies. Recommendation to provide improvement strategies and lessons learned to clearly delineate intended improvement.

Molina (CY 2019–2020)

1. General PIP Information
MCO Name: Molina
PIP Title: PCP and BH Collaborative Care Project (CY 2019–2020)
PIP Aim Statement: Molina revised PIP focus area for 2019–2021 to Improve referral compliance rate of members referred by the co-located and reverse co-located practitioner.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children

***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify):
2019–2021 PIP: Members who score more than 10 points on the PHQ-9 screening and are diagnosed with depression disorder by the MH Co-Located Practitioner

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

Provide codes to practitioners for reporting.

Provide reporting template for practitioners.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator 1: MH Co-located Practitioner to Improve Referral Compliance rate.	Not Reported.	Not Reported.	CY 2020 Q2	69%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Quality Indicator 2: Reverse Co-located Practitioner to Improve Referral Compliance Rate.	Not Reported.	Not Reported.	CY 2020 Q2	11%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

“Validated” means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):
☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year
☒ First re-measurement ☐ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

Validation rating # 2: EQRO’s overall confidence that the PIP produced significant evidence of improvement.
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

MCO strengths:

Molina provided a comprehensive background for the need to improve behavioral healthcare integration with medical care, citing research articles supporting collaborative care is consistently more effective.

EQRO recommendations:

Although Molina clearly indicates the PIP focus, describes the framework for data collections and analysis, and defines the improvement strategy, population, and time period, there is not an Aim Statement identified. Recommend developing Aim Statements that are clear, concise, measurable, and answerable, setting the direction for achieving tangible results.

Provider engagement was listed as the main interventions, providing codes and reporting templates. It is not clear from the documentation if Molina provide education or training to the providers. Recommendation to expand intervention description for this PIP.

Baseline data is provided in analysis; however, it is unclear what the baseline data represents. Recommendation to include description of baseline data and clearly identify time period for all reported data.

It is unclear if Molina identified the gaps in existing measures. Recommendation to evaluate appropriateness of measures and consider new measures when experiencing data reporting inaccuracies.

Molina included data methodology and sources and indicated outpatient medical/treatment record abstraction was utilized as a data source as well as a programmed pull from claims/encounters. It is not clear what the technical specifications were for the programmed pull or what was calculated from the record abstraction. Recommendation to clearly describe technical specifications for data pulls, and outline record abstraction specifications as well as relevant review tool and scoring methodology for record review.

Molina indicated medical records were reviewed, however, it was not clear that IRR was implemented. Recommendation to clearly articulate IRR performance with MRR.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended Molina consider this opportunity to include measures that capture changes in Enrollee satisfaction or experience of care.

Molina's PIP documents included an option to enter Statistical Test and Significance, however the statistical significance information was not included. Recommendation to perform and provide evidence of statistical testing of hypothesis and correlation to interventions.

Molina PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include appropriate cultural and linguistic approach with PIP process.

Molina provided data rates and qualitative analysis outlining the outcomes; however, the documentation provided did not clearly indicate improvement strategies. Recommendation to provide improvement strategies and lessons learned to clearly delineate intended improvement.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One administrative project in the area of reverse co-location and co-location of PH and BH and their integration.	Low Confidence: Molina initiated the project with a comprehensive description and documented phases of design and data collection, outcomes were reported and analyzed. Baseline data is provided in analysis; however, it is unclear what the baseline data reported represents and what the defined time period is for the data. Technical specifications were not identified for the programmed data pull or medical record review. Additionally, the medical record scoring methodology and the IRR process with MRR was not indicated within the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
One administrative project in the area of reverse co-location and co-location of PH and BH and their integration.	Low Confidence: Molina provided data supporting improvement for MH co-located referral compliance rate, however, reverse co-located referral compliance rate declined. Technical specifications and MRR criteria were not identified to evaluate the accuracy of data reported. Additionally, analysis for statistical significance was not identified.

PSM

1. General PIP Information
MCO Name: PSM
PIP Title: Improve the Communication with Behavioral Provider with PCP in Co-Location
PIP Aim Statement: The goal of this model is to support the PCP in identifying and treating patients with MH diagnosis and/or need for behavioral interventions.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**: Target age group not identified.
Target population description, such as duals, LTSS, or pregnant women (please specify): Medicaid members who received co-location services in a Primary Care Group.
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
2. Improvement Strategies or Interventions
Educational intervention with providers related to the importance of case discussions. Electronic Health Record flags to identify members for clinical case discussion. Providing CPT codes to ensure the provider can identify Enrollees that would benefit case discussions. Provider education and outreach.

3. PMs and Results						
PMs (be specific and indicate measure steward and NQF number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent re-measurement year (if applicable)**	**Most recent re-measurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Quality Indicator: Medicaid Enrollees who receive Co-location services in a Primary Care Group.	Baseline year not provided.	Data Not Provided.	CY 2022	30.5%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Baseline year not provided

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

MCO strengths:

PSM created a newsletter specifically for the co-location model aimed at enhancing awareness of the model.

PSM made a substantial investment in implementing the Co-location of Services Model and actively promoted this model within their Primary Care Groups, to ensure Enrollees have access to and can benefit from this form of service delivery.

EQRO recommendations:

PSM clearly outlines the goal of the PIP, but the absence of a clearly defined Aim Statement is notable. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

PSM PIP lacked a clearly defined baseline year or established period, hindering the accurate measurement of progress and effectiveness. It is recommended that PSM select a baseline year and a specified period for their PIP to ensure precise and meaningful analysis of the PIP's progress and outcomes.

PSM's PIP focuses on improving communication between BH professionals and the Primary Care Groups, but its impact on Enrollees' MH outcomes is unclear. It is recommended that PSM develop a strategy to measure and analyze how this enhanced communication affects MH outcomes, aligning PIP goals with concrete improvements in patient care.

PSM recognized and addressed various barriers and gaps by creating targeted interventions. However, the relationship between these interventions and tangible improvements in Enrollees' access to MH services and overall outcomes is not evident. It is recommended that PSM conducts a more thorough analysis and utilizes metrics to establish and document the effectiveness of these interventions in enhancing MH service accessibility and outcomes for Enrollees.

PSM's data analysis of the PIP did not indicate the use of continuous QI techniques or integration of lessons learned, limiting opportunities for enhancement in future iterations of the PIPs.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended PSM perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended PSM consider this opportunity to include measures that capture changes in Enrollee satisfaction or experience of care.

PSM PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include appropriate cultural and linguistic approach with the PIP process.

Data collection personnel and qualifications were not included in the PIP. It is recommended that PSM consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One administrative project in the area of co-location and reverse co-location of PH and BH, and their integration.	Low Confidence: The PIP did not include variables needed to identify appropriateness of care and measuring performance was limited to tracking individuals receiving an initial visit in a co-location setting and identifying when a clinical case discussion occurred with the PCP and BH professional. PIP did not clarify how the measure is identifying individuals requiring a clinical case discussion (e.g., BH or MH related ICD-10 codes). Additionally, the PIP did not provide baseline data. PSM's continuous QI methodology is not clearly identified and evaluation of successful improvement strategies was not included in the PIP.

PIP	EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
One administrative project in the area of co-location and reverse co-location of PH and BH, and their integration.	Low Confidence: The PIP showed improvement from 2020 to 2021, however quarterly data reported does not clearly show improvement from quarter to quarter, preventing interpretation of improvement. An evaluation of statistical significance in improvement was not identified.

Triple S

1. General PIP Information
MCO Name: Triple S
PIP Title: Improve Communication Between BH Providers and PCPs in Co-location.
PIP Aim Statement: Support the PCP in identifying and treating patients with MH diagnoses and/or need for behavioral interventions and discuss the cases to promote integrated services and to improve the communication.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): Patients who receive services in Primary Care Groups.

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions

CPT Code established in the provider system.

Provided education to promote and emphasize the importance of communications between medical and BH professionals.

Shared PCP contact lists to collocated providers.

Established case discussion meetings with collocated and PMG clinical staff.

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Quality Indicator: Improve the communication between BH providers and PCPs in Co-location	CY 2019 however not clearly articulated.	13%	CY 2022	43.6%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Third re-remeasurement.

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

MCO strengths:
Triple S' interventions incorporated a range of strategies for communication enhancement between medical and BH providers to improve health outcomes and quality of life and decrease fragmentation of care.

Despite challenges from a PHE affecting face to face interactions, Triple S pivoted and implemented strategies to continue engagement with Providers to reinforce case discussion processes.

EQRO recommendations:
Triple S' Aim Statement lacked specificity and measurability, necessary for setting clear, actionable goals. It is recommended to develop Aim Statements that are clear, concise, measurable, and answerable, thereby establishing a clear direction for achieving tangible results.

For Triple S to effectively measure progress and outcomes, it is crucial to clearly identify the baseline year and rate with each reporting cycle within the PIP structure. This foundation is essential for accurate and meaningful analysis. It is recommended that Triple S identify the baseline year to ensure precise and meaningful analysis of the PIP's progress and outcomes.

Triple S' PIP data analysis did not incorporate continuous QI techniques or effectively incorporate lessons learned. It is recommended the PIP identify its data collection methods as well as adopt and implement continuous QI methodologies such as PDSA or rapid cycle approaches and incorporating lessons learned to identify areas of opportunity within the PIP.

Analysis for statistical significance in change between initial and repeat measures was not present. It is recommended Triple S perform and provide evidence of statistical testing of hypothesis as well as a correlation to the improvement strategy.

PIP documents do not indicate a measure for Enrollee satisfaction. It is recommended Triple S consider this opportunity to include measures that capture Enrollee satisfaction or experience of care.

Triple S PIP documents did not include information regarding culturally or linguistically appropriate strategies in relation to the PIP. Recommendation to include an appropriate cultural and linguistic approach with the PIP process.

Data collection personnel qualifications were not clearly indicated in the PIP. It is recommended that Triple S consider this opportunity to include data collection personnel and relevant qualifications in the PIP structure.

PIP	EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases
One administrative project in the area of co-location and reverse co-location of PH and BH, and their integration.	Moderate Confidence: Triple S provided a comprehensive description and adhered to most phases of the protocol. Triple S has the opportunity to enhance the PIP Aim Statement by clearly defining the improvement strategy, target population, and measurable impact. Additionally, the PIP analysis did not clearly state the interpretation of the data or analysis of interventions.

PIP	EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement
One administrative project in the area of co-location and reverse co-location of PH and BH, and their integration.	Moderate Confidence: Triple S provided data supporting improvement, however analysis for statistical significance in improvement was not identified.

Section 4
Validation of PMs

Introduction

The PM Validation process assesses the accuracy of PMs reported by the MCO in accordance with 42 CFR § 438.358(b)(ii) and to determine the extent to which the MCO follows state specifications and reporting requirements. In addition to validation processes and the reported results, Mercer evaluates performance trends in comparison to national benchmarks. Mercer conducted this activity in accordance with 42 CFR § 438.358(b)(ii) using the analytic approach established in CMS EQR Protocol 2.

Validate the accuracy of Medicaid PMs reported by MCOs.

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of organizational charts, training materials, P&Ps, HEDIS Roadmaps, HEDIS final audit reports, data integration diagrams used for PM extraction, and other supporting documentation and descriptions included in the response to RFI. This review was conducted based on information submitted by the MCOs through the RFI and through on-site and virtual meetings held November 6–9, 2023 and November 15, 2023. The meetings involved participation from MCOs key leadership including, but not limited to vice presidents (VPs) and directors of business intelligence, analytics, operations, quality, etc.

Review Methodology and Data Collection

Mercer conducted the validation process in accordance with the CMS, EQR Protocol 2: Validation of PMs. The main objectives of PM Validation are to:

- Evaluate the accuracy of PM data collected by the MCO based on the measure specifications.
- Assess data integration and control for PM calculation to determine if the MCO has adequate processes in place to ensure data completeness and data quality.
- Review PM rates production processes to determine the MCO's ability to identify numerator and denominator eligible members accurately.

To accomplish these objectives, Mercer performed the following:

- Pre-Audit Activities — Mercer developed and distributed the RFI to gather information specific to the information systems used to collect the data used for PM rate calculation.
- Data Collection and Analysis — Mercer reviewed the responses submitted in the RFI and supporting documentation, which included the HEDIS Roadmaps and HEDIS Reports.

- On-Site Activities — Mercer conducted interviews with the MCO staff to discuss the information systems used to collect the data and to review processes used for collecting, storing, validating, and reporting the PM data.

Overall Assessment

The EQRO provides an overall validation rating of the PM results. The validation rating refers to the EQRO's overall confidence that the PM calculation adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis, and produced accurate HEDIS rates. Validation ratings are described in the following table.

High confidence	Moderate confidence	Low confidence	No confidence
All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.	After review of the documentation and discussion with MCO staff, it is determined that the MCO has met most of the requirements as required for the Met category.	MCO staff describes and verifies the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice.	After review of the documentation and discussion with MCO staff, it is determined that although some requirements have been met, the MCO has not met most of the requirements.

Measures Selected

For this review, Mercer conducted PM validation in accordance with CMS EQR Protocol 2 on six measures that were selected by Puerto Rico. The measures validated are outlined in the table below.

PM
PM 1: Cervical Cancer Screening (CCS-AD)
PM 2: Breast Cancer Screening (BCS-AD)
PM 3: Antidepressant Medication Management — Acute Phase (AMM-AD)
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Comparative Analysis — Overall Assessment Results

The tables that follow contain the results of the validation of the selected measures across the plans. EQRO reviewed numerous documents submitted as part of the RFI and conducted interviews with the MCO key stakeholders to make the determination on the overall assessment.

Notes:

- Data for MY 2017 were not required to be reported based on the ASES Normative Letter (March 23, 2018) issued by ASES stating that “In response to the current barriers faced by Puerto Rico since the hurricanes Irma and Maria, the Puerto Rico Health Insurance Administration will not request the MCOs to report the HEDIS 2018 for the Government Health Plan.”.
- Molina exited the market in 2020, therefore only MY 2018 and MY 2019 rates are available.
- PSM started operations at the end of 2018; therefore, no rates are available for MY 2018.
- Not all measures were required to be reported for each MY. ASES provides a Normative Letter to the MCOs outlining the required measures to be reported for each year.

GHP MY 2018 Results

PM	FMHP	MMM	Molina	PSM	Triple S
PM 1: Cervical Cancer Screening (CCS-AD)	High confidence	High confidence	High confidence	—	High confidence
PM 2: Breast Cancer Screening (BCS-AD)	High confidence	High confidence	High confidence	—	High confidence
PM 3: Antidepressant Medication Management — Acute Phase (AMM-AD)	High confidence	High confidence	High confidence	—	High confidence
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	High confidence	High confidence	High confidence	—	High confidence
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	NQ^	NQ^	High confidence	—	NQ^
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	High confidence	High confidence	High confidence	—	NA

NQ^ The measure was not required to be reported by ASES

NA — Rate not available due to small denominator, continuous enrollment requirements, etc.

GHP MY 2019 Results

PM	FMHP	MMM	Molina	PSM	Triple S
PM 1: Cervical Cancer Screening (CCS-AD)	High confidence	High confidence	High confidence	High confidence	Low confidence
PM 2: Breast Cancer Screening (BCS-AD)	High confidence	High confidence	High confidence	NA	Low confidence
PM 3: Antidepressant Medication Management — Acute Phase (AMM-AD)	High confidence	High confidence	High confidence	High confidence	Low confidence
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	High confidence	High confidence	High confidence	High confidence	Low confidence
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	NQ^	NQ^	High confidence .	NQ^	NQ^
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	High confidence	High confidence	High confidence	NA	Low confidence

NQ^ The measure was not required to be reported by ASES
NA — Rate not available due to small denominator, continuous enrollment requirements, etc.

GHP MY 2020 Results

PM	FMHP	MMM	Molina	PSM	Triple S
PM 1: Cervical Cancer Screening (CCS-AD)	High confidence	High confidence	—	High confidence	Low confidence
PM 2: Breast Cancer Screening (BCS-AD)	High confidence	High confidence	—	NA	Low confidence
PM 3: Antidepressant Medication Management — Acute Phase (AMM-AD)	High confidence	High confidence	—	High confidence	Low confidence
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	High confidence	NQ^	—	NQ^	NQ^
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	High confidence	NQ^	—	High confidence	Low confidence

PM	FMHP	MMM	Molina	PSM	Triple S
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	No confidence	High confidence	—	High confidence	Low confidence

NQ^ The measure was not required to be reported by ASES
NA **—** Rate not available due to small denominator, continuous enrollment requirements, etc.

GHP MY 2021 Results

PM	FMHP	MMM	Molina	PSM	Triple S
PM 1: Cervical Cancer Screening (CCS-AD)	High confidence	High confidence	—	High confidence	High confidence
PM 2: Breast Cancer Screening (BCS-AD)	High confidence	High confidence	—	High confidence	High confidence
PM 3: Antidepressant Medication Management — Acute Phase (AMM-AD)	High confidence	High confidence	—	High confidence	High confidence
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	High confidence	NQ^	—	High confidence	High confidence
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	High confidence	High confidence	—	High confidence	High confidence
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	High confidence	High confidence	—	High confidence	High confidence

NQ^ The measure was not required to be reported by ASES

GHP MY 2022 Results

PM	FMHP	MMM	Molina	PSM	Triple S
PM 1: Cervical Cancer Screening (CCS-AD)	High confidence	High confidence	—	High confidence	High confidence
PM 2: Breast Cancer Screening (BCS-AD)	High confidence	High confidence	—	High confidence	High confidence
PM 3: Antidepressant Medication Management — Acute Phase (AMM-AD)	High confidence	High confidence	—	High confidence	High confidence

PM	FMHP	MMM	Molina	PSM	Triple S
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	High confidence	High confidence	—	High confidence	High confidence
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	High confidence	High confidence	—	High confidence	High confidence
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	High confidence	High confidence	—	High confidence	High confidence

Comparative Analysis — Rates Results

The following tables contain the rates of the selected measures across the plans. EQRO reviewed numerous documents submitted as part of the RFI and conducted interviews with the MCO key stakeholders to make the determination on the overall assessment.

GHP MY 2018 results

PM	FMHP	MMM	Molina	PSM	Triple S
PM 1: Cervical Cancer Screening (CCS-AD)	50.0%	52.99%	59.1%	—	45.90%
PM 2: Breast Cancer Screening (BCS-AD)	58.8%	62.3%	70.9%	—	56.64%
PM 3: Antidepressant Medication Management — Acute Phase (AMM-AD)	41.6%	48.0%	44.6%	—	44.74%
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	6.9%	42.67%	4.0%	—	0.00%
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	NQ^	NQ^	NQ^	—	NQ^
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	55.9%	100%	66.0%	—	NA

NQ^ The measure was not required to be reported by ASES

NA **—** Rate not available due to small denominator, continuous enrollment requirements, etc.

GHP MY 2019 Results

PM	FMHP	MMM	Molina	PSM	Triple S
PM 1: Cervical Cancer Screening (CCS-AD)	45.5%	43.1%	60.0%	28.1%	27.02%
PM 2: Breast Cancer Screening (BCS-AD)	62.5%	67.3%	74.2%	NA	53.14%
PM 3: Antidepressant Medication Management — Acute Phase (AMM-AD)	37.5%	55.0%	49.7%	65.9%	57.08%
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	4.2%	55.2%	46.1%	0%	0.22%
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	NQ^	NQ^	96.4%	NA	NQ^
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	70.8%	75.0%	91.3%	NA	46.15%

NQ^ The measure was not required to be reported by ASES.
NA — Rate not available due to small denominator, continuous enrollment requirements, etc.

GHP MY 2020 Results

PM	FMHP	MMM	Molina	PSM	Triple S
PM 1: Cervical Cancer Screening (CCS-AD)	36.5%	45.9%	—	37.1%	32.50%
PM 2: Breast Cancer Screening (BCS-AD)	55.0%	61.7%	—	NA	42.70%
PM 3: Antidepressant Medication Management — Acute Phase (AMM-AD)	47.2%	37.5%	—	55.3%	49.8%
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	1.5%	NQ^	—	NQ^	NQ^
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	96.7%	NQ^	—	79.1%	95.35%

PM	FMHP	MMM	Molina	PSM	Triple S
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	NR	69.6%	—	41.8%	35.8%

NQ^ The measure was not required to be reported by ASES.
NA — Rate not available due to small denominator, continuous enrollment requirements, etc.
NR **—** Not reported

GHP MY 2021 Results

PM	FMHP	MMM	Molina	PSM	Triple S
PM 1: Cervical Cancer Screening (CCS-AD)	42.2%	47.7%	—	42.5%	38.31%
PM 2: Breast Cancer Screening (BCS-AD)	55.3%	52.8%	—	59.0%	59.18%
PM 3: Antidepressant Medication Management — Acute Phase (AMM-AD)	44.2%	53.3%	—	67.1%	54.02%
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	3.0%	NQ^	—	2.1%	1.72%
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	96.9%	95.3%	—	78.0%	94.72%
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	71.4%	70.2%	—	45.5%	41.96%

NQ^ The measure was not required to be reported by ASES.

GHP MY 2022 Results

PM	FMHP	MMM	Molina	PSM	Triple S
PM 1: Cervical Cancer Screening (CCS-AD)	42.4%	50.4%	—	51.3%	46.01%
PM 2: Breast Cancer Screening (BCS-AD)	56.0%	62.0%	—	70.8%	65.14%
PM 3: Antidepressant Medication Management — Acute Phase (AMM-AD)	31.4%	49.1%	—	60.0%	49.64%

PM	FMHP	MMM	Molina	PSM	Triple S
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	1.1%	1.46%	—	1.8%	2.80%
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	97.4%	96.5%	—	81.6%	93.39%
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	NA	85.9%	—	52.4%	65.5%

NA **—** Rate not available due to small denominator, continuous enrollment requirements, etc.

Comparative Analysis — Plan Results of Selected Measures

FMHP Results

Cervical Cancer Screening (CCS-AD)

Cervical Cancer Screening (CCS-AD) Overview

MCO name: FMHP

PM name: Cervical Cancer Screening (CCS-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

Cervical Cancer Screening (CCS-AD)

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including women 24–64 years as of December 31 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include the number of women who were screened for cervical cancer and met the specific testing criteria as defined by the NCQA.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022 and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

Cervical Cancer Screening (CCS-AD) Results

PM	2018	2019	2020	2021	2022
Numerator	15997	21853	22272	32660	34428
Denominator	31984	47985	61080	77327	81188
Rate	50.0%	45.5%	36.5%	42.2%	42.4%

Cervical Cancer Screening (CCS-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

Cervical Cancer Screening (CCS-AD)

EQRO recommendations for improvement of PM calculation: None.

Breast Cancer Screening (BCS-AD)

Breast Cancer Screening (BCS-AD) Overview

MCO name: FMHP

PM name: Breast Cancer Screening (BCS-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including women 52–74 years as of December 31 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include women that had one or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the MY and December 31 of the MY.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022, and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

Breast Cancer Screening (BCS-AD)

Breast Cancer Screening (BCS-AD) Results

PM	2018	2019	2020	2021	2022
Numerator	5837	5263	3488	9566	11885
Denominator	9931	8428	6340	17298	21220
Rate	58.8%	62.5%	55.0%	55.3%	56.0%

Breast Cancer Screening (BCS-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Antidepressant Medication Management — Acute Phase (AMM-AD)

Antidepressant Medication Management — Acute Phase (AMM-AD) Overview

MCO name: FMHP

PM name: Antidepressant Medication Management — Acute Phase (AMM-AD)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):
_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☐ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Based on the NCQA definition of the eligible population including members 18 years and older as of April 30 of the MY.

Definition of numerator (describe):
Based on the NCQA definition of the numerator and include members who remained on an antidepressant medication for at least 84 days (12 weeks).

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022, and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

Antidepressant Medication Management — Acute Phase (AMM-AD) Results

PM	2018	2019	2020	2021	2022
Numerator	3298	493	1400	1191	854
Denominator	7928	1313	2963	2697	2718
Rate	41.6%	37.5%	47.2%	44.2%	31.4%

Antidepressant Medication Management — Acute Phase (AMM-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Childhood Immunization Status Combo 3 (CIS-CH) Overview

MCO name: FMHP

PM name: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including children who turn two years of age during the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include children who received immunizations as defined by NCQA specifications.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022, and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

Childhood Immunization Status Combo 3 (CIS-CH) Results

PM	2018	2019	2020	2021	2022
Numerator	233	77	41	101	34
Denominator	3390	1840	2769	3374	2976
Rate	6.9%	4.2%	1.5%	3.0%	1.1%

Childhood Immunization Status Combo 3 (CIS-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Asthma Medication Ratio: 5 to 18 (AMR-CH)

Asthma Medication Ratio: 5 to 18 (AMR-CH) Overview

MCO name: FMHP

PM name: Asthma Medication Ratio: 5 to 18 (AMR-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Asthma Medication Ratio: 5 to 18 (AMR-CH)

Definition of denominator (describe):
Based on the NCQA definition of the eligible population limiting to children ages 5–18 years as of December 31 of the MY.

Definition of numerator (describe):
Based on the NCQA definition of the numerator and include the number of members who have a medication ratio of 0.50 or greater during the MY; limit to children 5–18 years.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022, and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

Asthma Medication Ratio: 5 to 18 (AMR-CH) Results

PM	2018	2019	2020		2021		2022	
			5–11	12–18	5–11	12–18	5–11	12–18
Numerator	NQ^	NQ^	305	158	237	169	111	79
Denominator	NQ^	NQ^	308	171	239	180	114	81
Rate	NQ^	NQ^	99.0%	92.4%	99.2%	93.9%	97.4%	97.5%

NQ^ The measure was not required to be reported by ASES.

Asthma Medication Ratio: 5 to 18 (AMR-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☐ Not applicable (ISCA not reviewed)
ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.
☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Overview

MCO name: FMHP

PM name: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including children 6 years as of March 1 of the year prior to the MY to 12 years as of the last calendar day of February of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include members 6–12 years of age with a 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.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☒ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022, and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Results

PM	2018		2019		2020		2021		2022	
	Initiation	Continuation	Initiation	Continuation	Initiation	Continuation	Initiation	Continuation	Initiation	Continuation
Numerator	536	80	423	17	665	NR	464	55	493	
Denominator	1215	143	935	24	1156	NR	701	77	765	
Rate	44.1%	55.9%	45.2%	70.8%	57.5%		66.2%	71.4%	64.4%	NA

NA — Rate not available due to small denominator, continuous enrollment requirements, etc. ^

NR — Not reported

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ The confidence varied between the reporting years with high confidence for MY2018, MY2019, MY2021, MY2022 and no confidence for MY2020 for C&M as no data were submitted and output generated from HEDIS is missing this measure.

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

MMM Results

Cervical Cancer Screening (CCS-AD)

1. Cervical Cancer Screening (CCS-AD) Overview

MCO name: MMM

PM name: Cervical Cancer Screening (CCS-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including women 24–64 years as of December 31 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include the number of women who were screened for cervical cancer and met the specific testing criteria as defined by the NCQA.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022, and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

2. Cervical Cancer Screening (CCS-AD) Results

PM	MY 2018	MY 2019	MY 2020	MY 2021	MY 2022

Cervical Cancer Screening (CCS-AD)

1. Cervical Cancer Screening (CCS-AD) Overview

Numerator	18,336	27,871	36,030	45,889	50,296
Denominator	34,600	64,737	78,476	96,240	99,830
Rate	52.99%	43.10%	45.9%	47.7%%	50.38%

3. Cervical Cancer Screening (CCS-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Breast Cancer Screening (BCS-AD)

1. Breast Cancer Screening (BCS-AD) Overview

MCO name: MMM

PM name: Breast Cancer Screening (BCS-AD)

Breast Cancer Screening (BCS-AD)

1. Breast Cancer Screening (BCS-AD) Overview

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including women 52–74 years as of December 31 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include women that had one or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the MY and December 31 of the MY.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022, and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

2. Breast Cancer Screening (BCS-AD) Results

PM	MY 2018	MY 2019	MY 2020	MY 2021	MY 2022
Numerator	7,350	7,500	4,763	14,273	19,653
Denominator	11,793	11,142	7,720	27,035	31,693
Rate	62.33%	67.3%	61.7%	52.8%	62.01%

Breast Cancer Screening (BCS-AD)

1. Breast Cancer Screening (BCS-AD) Overview

3. Breast Cancer Screening (BCS-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Antidepressant Medication Management — Acute Phase (AMM-AD)

1. Antidepressant Medication Management — Acute Phase (AMM-AD) Overview

MCO name: MMM

PM name: Antidepressant Medication Management — Acute Phase (AMM-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Antidepressant Medication Management — Acute Phase (AMM-AD)

1. Antidepressant Medication Management — Acute Phase (AMM-AD) Overview

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including members 18 years and older as of April 30 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include members who remained on an antidepressant medication for at least 84 days (12 weeks).

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022, and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

2. Antidepressant Medication Management — Acute Phase (AMM-AD) Results

PM	MY 2018	MY 2019	MY 2020	MY 2021	MY 2022
Numerator	2,403	2,410	1,772	2,283	1,963
Denominator	5,005	4,381	4,728	4,131	3,999
Rate	48.01%	55.0%	37.5%	53.3%	49.09%

3. Antidepressant Medication Management — Acute Phase (AMM-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Antidepressant Medication Management — Acute Phase (AMM-AD)

1. Antidepressant Medication Management — Acute Phase (AMM-AD) Overview

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

1. Childhood Immunization Status Combo 3 (CIS-CH) Overview

MCO name: MMM

PM name: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including children who turn 2 years of age during the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include children who received immunizations as defined by NCQA specifications.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022, and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

2. Childhood Immunization Status Combo 3 (CIS-CH) Results

PM	MY 2018	MY 2019	MY 2020	MY 2021	MY 2022
Numerator	1,363	227	NQ^	NQ^	40
Denominator	3,194	411	NQ^	NQ^	2,736
Rate	42.67%	55.2%	NQ^	NQ^	1.46%

NQ^ The measure was not required to be reported by ASES.

3. Childhood Immunization Status Combo 3 (CIS-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Asthma Medication Ration: 5 to 18 (AMR-CH)

1. Asthma Medication Ratio: 5 to 18 (AMR-CH) Overview

MCO name: MMM

PM name: Asthma Medication Ratio: 5 to 18 (AMR-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population limiting to children ages 5 to 18 as of December 31 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include the number of members who have a medication ratio of 0.50 or greater during the MY; limit to children 5–18 years of age.

Asthma Medication Ration: 5 to 18 (AMR-CH)

1. Asthma Medication Ratio: 5 to 18 (AMR-CH) Overview

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022, and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

Asthma Medication Ration: 5 to 18 (AMR-CH)

2. Asthma Medication Ratio: 5 to 18 (AMR-CH) Results

PM	MY 2018	MY 2019	MY 2020	MY 2021		MY 2022	
				5–11	12–18	5–11	12–18
Numerator	NQ^	NQ^	NQ^	318	191	405	230
Denominator	NQ^	NQ^	NQ^	327	207	408	250
Rate	NQ^	NQ^	NQ^	97.3%	92.3%	99.3%	92.0%

NQ^ The measure was not required to be reported by ASES

3. Asthma Medication Ratio: 5 to 18 (AMR-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

1. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Overview

MCO name: MMM

PM name: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):
_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Based on the NCQA definition of the eligible population including children 6 years as of March 1 of the year prior to the MY to 12 years as of the last calendar day of February of the MY.

Definition of numerator (describe):
Based on the NCQA definition of the numerator and include members 6–12 years of age with a 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.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022, and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

2. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Results

PM	MY 2018		MY 2019		MY 2020		MY 2021		MY 2022	
	Initiation	Continuation	Initiation	Continuation	Initiation	Continuation	Initiation	Continuation	Initiation	Continuation
Numerator	1,350	35	483	66	440	64	315	47	470	91
Denominator	1,460	35	905	88	917	92	572	67	700	106
Rate	92.47%	100%	53.4%	75.0%	47.98%	69.6%	55.07%	70.2%	67.1%	85.9%

3. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Molina Results

Cervical Cancer Screening (CCS-AD)

1. Cervical Cancer Screening (CCS-AD) Overview

MCO name: Molina

PM name: Cervical Cancer Screening (CCS-AD)

Cervical Cancer Screening (CCS-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including women 24–64 years as of December 31 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include the number of women who were screened for cervical cancer and met the specific testing criteria as defined by the NCQA.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): MY 2018 and MY 2019.

2. Cervical Cancer Screening (CCS-AD) Results

PM	MY 2018	MY 2019
Numerator	16,412	18,850
Denominator	27,757	31,419
Rate	59.13%	60.00%

Cervical Cancer Screening (CCS-AD)

3. Cervical Cancer Screening (CCS-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☒ Not applicable (ISCA not reviewed)

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Breast Cancer Screening (BCS-AD)

1. Breast Cancer Screening (BCS-AD) Overview

MCO name: Molina

PM name: Breast Cancer Screening (BCS-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

Breast Cancer Screening (BCS-AD)

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data

☐ Medical records (describe):

☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including women 52–74 years as of December 31 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include women that had one or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the MY and December 31 of the MY.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): MY 2018 and MY 2019.

2. Breast Cancer Screening (BCS-AD) Results

PM	MY 2018	MY 2019
Numerator	5,849	7,203
Denominator	8,251	9,709
Rate	70.89%	74.19%

3. Breast Cancer Screening (BCS-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☒ Not applicable (ISCA not reviewed)

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Breast Cancer Screening (BCS-AD)

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Antidepressant Medication Management — Acute Phase (AMM-AD)

1. Antidepressant Medication Management — Acute Phase (AMM-AD) Overview

MCO name: Molina

PM name: Antidepressant Medication Management — Acute Phase (AMM-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including members 18 years and older as of April 30 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include members who remained on an antidepressant medication for at least 84 days (12 weeks).

Antidepressant Medication Management — Acute Phase (AMM-AD)

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): MY 2018 and MY 2019

2. Antidepressant Medication Management — Acute Phase (AMM-AD) Results

PM	MY 2018	MY 2019
Numerator	1,969	1,190
Denominator	4,420	2,397
Rate	44.55%	49.65%

3. Antidepressant Medication Management — Acute Phase (AMM-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☒ Not applicable (ISCA not reviewed)

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

1. Childhood Immunization Status Combo 3 (CIS-CH) Overview

MCO name: Molina

PM name: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including children who turn two years of age during the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include children who received immunizations as defined by NCQA specifications.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): MY 2018 and MY 2019.

2. Childhood Immunization Status Combo 3 (CIS-CH) Results

PM	MY 2018	MY 2019
Numerator	156	547
Denominator	3,858	1,187
Rate	4.04%	46.08%

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

3. Childhood Immunization Status Combo 3 (CIS-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☒ Not applicable (ISCA not reviewed)

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Asthma Medication Ratio: 5 to 18 (AMR-CH)

1. Asthma Medication Ratio: 5 to 18 (AMR-CH) Overview

MCO name: Molina

PM name: Asthma Medication Ratio: 5 to 18 (AMR-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Asthma Medication Ratio: 5 to 18 (AMR-CH)

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population limiting to children ages 5–18 years as of December 31 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include the number of members who have a medication ratio of 0.50 or greater during the MY; limit to children 5–18 years of age.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): MY 2018 and MY 2019.

2. Asthma Medication Ratio: 5 to 18 (AMR-CH) Results

PM	MY 2018	MY 2019	
		5-11	12-18
Numerator	NQ^	391	170
Denominator	NQ^	399	183
Rate	NQ^	97.99%	92.90%

NQ^ The measure was not required to be reported by ASES.

3. Asthma Medication Ratio: 5 to 18 (AMR-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☒ Not applicable (ISCA not reviewed)

Asthma Medication Ratio: 5 to 18 (AMR-CH)

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

1. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Overview

MCO name: Molina

PM name: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Definition of denominator (describe):
Based on the NCQA definition of the eligible population including children six years as of March 1 of the year prior to the MY to 12 years as of the last calendar day of February of the MY.

Definition of numerator (describe):
Based on the NCQA definition of the numerator and include members 6–12 years of age with a 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 (nine months) after the Initiation Phase ended.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): MY 2018 and MY 2019.

2. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Results

PM	MY 2018		MY 2019	
	Initiation	Continuation	Initiation	Continuation
Numerator	331	35	363	21
Denominator	769	53	654	23
Rate	43.04%	66.04%	55.50%	91.30%

3. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☒ Not applicable (ISCA not reviewed)

Describe any findings from MRR that affected the reliability or validity of the PM results.
☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

EQRO recommendations for improvement of PM calculation: None.

PSM Results

Cervical Cancer Screening (CCS-AD)

1. Cervical Cancer Screening (CCS-AD) Overview

MCO name: PSM

PM name: Cervical Cancer Screening (CCS-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including women 24–64 years as of December 31 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include the number of women who were screened for cervical cancer and met the specific testing criteria as defined by the NCQA.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Cervical Cancer Screening (CCS-AD)

Measurement period (start/end date): January 1, 2022–December 31, 2022 and prior years MY 2019, MY 2020, and MY 2021.

2. Cervical Cancer Screening (CCS-AD) Results

PM	MY 2019	MY 2020	MY 2021	MY 2022
Numerator	4,888	7,779	20,904	27,390
Denominator	17,422	20,972	49,228	53,429
Rate	28.1%	37.09%	42.5%	51.3%

3. Cervical Cancer Screening (CCS-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Breast Cancer Screening (BCS-AD)

1. Breast Cancer Screening (BCS-AD) Overview

MCO name: PSM

PM name: Breast Cancer Screening (BCS-AD)

Breast Cancer Screening (BCS-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including women 52–74 years as of December 31 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include women that had one or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the MY and December 31 of the MY.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022 and prior years MY 2019, MY 2020, and MY 2021.

2. Breast Cancer Screening (BCS-AD) Results

PM	MY 2019	MY 2020	MY 2021	MY 2022
Numerator	NA	NA	2,567	7,736
Denominator	NA	NA	4,352	10,391
Rate	NA	NA	59.0%	70.8%

NA — Rate not available due to small denominator, continuous enrollment requirements, etc.

Breast Cancer Screening (BCS-AD)

3. Breast Cancer Screening (BCS-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Antidepressant Medication Management — Acute Phase (AMM-AD)

1. Antidepressant Medication Management — Acute Phase (AMM-AD) Overview

MCO name: PSM

PM name: Antidepressant Medication Management — Acute Phase (AMM-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

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Antidepressant Medication Management — Acute Phase (AMM-AD)

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including members 18 years and older as of April 30 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include members who remained on an antidepressant medication for at least 84 days (12 weeks).

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022 and prior years MY 2019, MY 2020, and MY 2021.

2. Antidepressant Medication Management — Acute Phase (AMM-AD) Results

PM	MY 2019	MY 2020	MY 2021	MY 2022
Numerator	226	599	1,603	1,453
Denominator	343	1,083	2,389	2,423
Rate	65.9%	55.31%	67.1%	60.0%

3. Antidepressant Medication Management — Acute Phase (AMM-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Antidepressant Medication Management — Acute Phase (AMM-AD)

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

1. Childhood Immunization Status Combo 3 (CIS-CH) Overview

MCO name: PSM

PM name: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including children who turn two years of age during the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include children who received immunizations as defined by NCQA specifications.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022 and prior years MY 2019, MY 2020, and MY 2021.

2. Childhood Immunization Status Combo 3 (CIS-CH) Results

PM	MY 2019	MY 2020	MY 2021	MY 2022
Numerator	0	NQ^	30	37
Denominator	227	NQ^	1,411	2,108
Rate	0%	NQ^	2.1%	1.8%

NQ^ The measure was not required to be reported by ASES

3. Childhood Immunization Status Combo 3 (CIS-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Asthma Medication Ratio: 5 to 18 (AMR-CH)

1. Asthma Medication Ratio: 5 to 18 (AMR-CH) Overview

MCO name: PSM

PM name: Asthma Medication Ratio: 5 to 18 (AMR-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population limiting to children ages 5–18 years of age as of December 31 of the MY.

Asthma Medication Ratio: 5 to 18 (AMR-CH)

Definition of numerator (describe):
Based on the NCQA definition of the numerator and include the number of members who have a medication ratio of 0.50 or greater during the MY; limit to children 5–-18 years of age.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022 and prior years MY 2019, MY 2020, and MY 2021.

2. Asthma Medication Ratio: 5 to 18 (AMR-CH) Results

PM	MY 2019	MY 2020		MY 2021		MY 2022	
		5–11	12–18	5–11	12–18	5–11	12–18
Numerator	NA	185	121	166	119	377	266
Denominator	NA	246	141	213	146	474	314
Rate	NA	75.2%	85.8%	77.9%	81.5%	79.5%	84.7%

NA — Rate not available due to small denominator, continuous enrollment requirements, etc.

3. Asthma Medication Ratio: 5 to 18 (AMR-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☐ Not applicable (ISCA not reviewed)
ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.
☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

1. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Overview

MCO name: PSM

PM name: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):
_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Based on the NCQA definition of the eligible population including children six years as of March 1 of the year prior to the MY to 12 years as of the last calendar day of February of the MY.

Definition of numerator (describe):
Based on the NCQA definition of the numerator and include members 6–12 years of age with a 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.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022 and prior years MY 2019, MY 2020, and MY 2021.

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)								
2. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Results								
PM	**MY 2019**		**MY 2020**		**MY 2021**		**MY 2022**	
			Initiation	**Continuation**	**Initiation**	**Continuation**	**Initiation**	**Continuation**
Numerator	NA	NA	123	69	93	46	165	77
Denominator	NA	NA	329	165	212	101	346	147
Rate	NA	NA	37.4%	41.8%	43.9%	45.5%	47.7%	52.4%

NA — Rate not available due to small denominator, continuous enrollment requirements, etc.

3. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Triple S Results

Cervical Cancer Screening (CCS-AD)

1. Cervical Cancer Screening (CCS-AD) Overview

MCO name: Triple S

PM name: Cervical Cancer Screening (CCS-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)

Cervical Cancer Screening (CCS-AD)

☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including women 24–64 years as of December 31 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include the number of women who were screened for cervical cancer and met the specific testing criteria as defined by the NCQA.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022 and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

2. Cervical Cancer Screening (CCS-AD) Results

PM	MY 2018	MY 2019	MY 2020	MY 2021	MY 2022
Numerator	23,157	22,663	35,419	52,345	66,707
Denominator	50,453	83,860	108,880	136,621	144,996
Rate	45.90%	27.02%	32.5%	38.31%	46.01%

Cervical Cancer Screening (CCS-AD)

3. Cervical Cancer Screening (CCS-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ Please refer to the table above *Results of Selected Measures* for the validation rating for each year under review.

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Breast Cancer Screening (BCS-AD)

1. Breast Cancer Screening (BCS-AD) Overview

MCO name: Triple S

PM name: Breast Cancer Screening (BCS-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Breast Cancer Screening (BCS-AD)

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including women 52–74 years as of December 31 of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include women that had one or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the MY and December 31 of the MY.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022 and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

2. Breast Cancer Screening (BCS-AD) Results

PM	MY 2018	MY 2019	MY 2020	MY 2021	MY 2022
Numerator	8,521	6,994	3,920	20,567	26,005
Denominator	15,044	13,161	9,181	34,753	39,924
Rate	56.64%	53.14%	42.7%	59.18%	65.14%

3. Breast Cancer Screening (BCS-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Breast Cancer Screening (BCS-AD)

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ Please refer to the table above *Results of Selected Measures* for the validation rating for each year under review.

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Antidepressant Medication Management — Acute Phase (AMM-AD)

1. Antidepressant Medication Management — Acute Phase (AMM-AD) Overview

MCO name: Triple S

PM name: Antidepressant Medication Management — Acute Phase (AMM-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Antidepressant Medication Management — Acute Phase (AMM-AD)

Definition of denominator (describe):
Based on the NCQA definition of the eligible population including members 18 years and older as of April 30 of the MY.

Definition of numerator (describe):
Based on the NCQA definition of the numerator and include members who remained on an antidepressant medication for at least 84 days (12 weeks).

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022 and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

2. Antidepressant Medication Management — Acute Phase (AMM-AD) Results

PM	MY 2018	MY 2019	MY 2020	MY 2021	MY 2022
Numerator	51	1,064	2,742	3,379	3,402
Denominator	114	1,864	5,507	6,255	6,853
Rate	44.74%	57.08%	49.8%	54.02%	49.64%

3. Antidepressant Medication Management — Acute Phase (AMM-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☐ Not applicable (ISCA not reviewed)
ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.
☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ Please refer to the table above *Results of Selected Measures* for the validation rating for each year under review.
"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

1. Childhood Immunization Status Combo 3 (CIS-CH) Overview

MCO name: Triple S

PM name: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including children who turn 2 years of age during the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include children who received immunizations as defined by NCQA specifications.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022 and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

2. Childhood Immunization Status Combo 3 (CIS-CH) Results

PM	MY 2018	MY 2019	MY 2020	MY 2021	MY 2022

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)					
Numerator	0	5	NQ^	81	127
Denominator	382	2,273	NQ^	4,713	4,537
Rate	0%	0.22%	NQ^	1.72%	2.80%

NQ^ The measure was not required to be reported by ASES.

3. Childhood Immunization Status Combo 3 (CIS-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ Please refer to the table above *Results of Selected Measures* for the validation rating for each year under review.

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Asthma Medication Ratio: 5 to 18 (AMR-CH)

1. Asthma Medication Ratio: 5 to 18 (AMR-CH) Overview

MCO name: Triple S

PM name: Asthma Medication Ratio: 5 to 18 (AMR-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)

Asthma Medication Ratio: 5 to 18 (AMR-CH)

☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Based on the NCQA definition of the eligible population limiting to children ages 5–18 years as of December 31 of the MY.

Definition of numerator (describe):
Based on the NCQA definition of the numerator and include the number of members who have a medication ratio of 0.50 or greater during the MY; limit to children 5–18 years.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022 and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

2. Asthma Medication Ratio: 5 to 18 (AMR-CH) Results

PM	MY 2018	MY 2019	MY 2020		MY 2021		MY 2022	
			5–11	12–18	5–11	12–18	5–11	12–18
Numerator	NQ^	NQ^	413	264	440	332	509	409
Denominator	NQ^	NQ^	422	288	449	366	534	449
Rate			97.9%	91.7%	98.00%	90.71%	95.32%	91.09%

NQ^ The measure was not required to be reported by ASES.

3. Asthma Medication Ratio: 5 to 18 (AMR-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the technical specifications.

Asthma Medication Ratio: 5 to 18 (AMR-CH)

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ Please refer to the table above *Results of Selected Measures* for the validation rating for each year under review.

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

1. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Overview

MCO name: Triple S

PM name: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data

☐ Medical records (describe):

☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Based on the NCQA definition of the eligible population including children 6 years as of March 1 of the year prior to the MY to 12 years as of the last calendar day of February of the MY.

Definition of numerator (describe):

Based on the NCQA definition of the numerator and include members 6–12 years of age with a 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.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2022–December 31, 2022 and prior years MY 2018, MY 2019, MY 2020, and MY 2021.

2. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Results

PM	MY 2018		MY 2019		MY 2020		MY 2021		MY 2022	
	Initiation	Continuation	Initiation	Continuation	Initiation	Continuation	Initiation	Continuation	Initiation	Continuation
Numerator	NA	NA	95	6	287	44	292	47	492	67
Denominator	NA	NA	223	13	1,291	123	880	112	1018	103
Rate	NA	NA	42.60%	46.15%	22.2%	35.8%	33.18%	41.96%	48.33%	65.05%

NA — Rate not available due to small denominator, continuous enrollment requirements, etc.

3. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)
ISCA review did not identify any findings specific to this measure.
Describe any findings from MRR that affected the reliability or validity of the PM results. ☒ Not applicable (MRR not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation. N/A
Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ Please refer to the table above *Results of Selected Measures* for the validation rating for each year under review. "Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.
EQRO recommendations for improvement of PM calculation: None.

Section 5

Information Systems Capabilities Assessment

Introduction

CMS regulations require that each MCO undergo an ISCA to enhance the review of the PMs. The focus of the review is on components of MCO information systems that contribute to claims receipt and processing, data integrity and PM production. This is to ensure that the system can collect data on Enrollee and provider characteristics and on services furnished to Enrollees through an encounter data system or other methods. The system must be able to ensure that data received from providers are accurate and complete, verify the timeliness of reported data; screen the data for consistency; and collect service information in standardized formats to the extent feasible and appropriate.

Mercer conducted the EQR ISCA review for period of 2018–2022. This independent review of the MCO's information systems was conducted to support the EQR mandatory activity outlined in 42 CFR § 438.358. To complete this assessment Mercer used the current version of the CMS EQR Protocol 5 — Appendix V, Attachment A, along with comprehensive enhancements to the ISCA to reflect State-specific regulations, standards, and requirements communicated to the MCOs through the contract with Puerto Rico.

Mercer's EQR ISCA process included review of submitted materials and information, as well as interviews and live systems demonstrations that were conducted virtually in May 2023 and on-site and virtually in November 2023. The November meetings involved participation from MCO leadership including, but not limited to directors and VPs of HEDIS, Information Technology (IT), Analytics, Payment Integrity, Audit, Operations, etc.

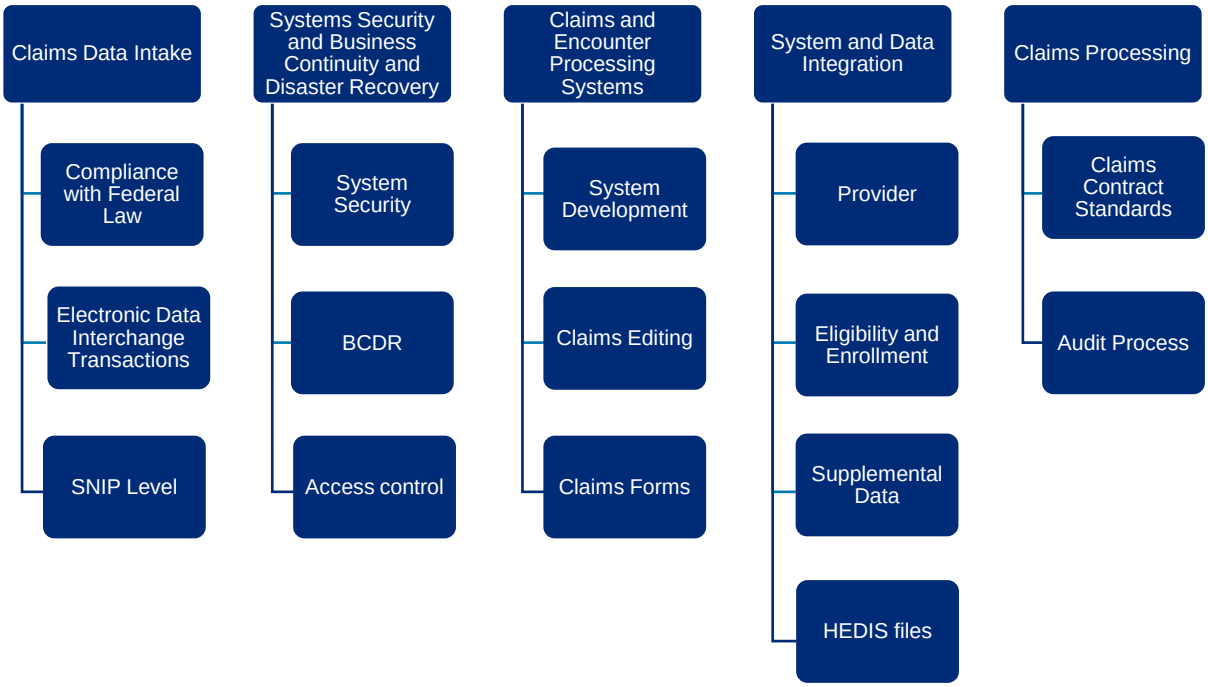
The ISCA evaluation conducted by Mercer, with Puerto Rico staff in attendance, focused on the core information systems and processes illustrated below.

Process and Documentation Reviewed

Mercer's approach to evaluating MCOs' data capabilities included four steps, outlined below:

- Establishing evaluation criteria to standardize reviews.
- Developing and distributing an RFI to collect relevant information from the MCOs.
- Analyzing the information submitted in response to the RFI.
- Conducting virtual reviews to confirm understanding and analysis of the information submitted in response to the RFI, clarifying any outstanding questions, and identifying any necessary follow-up items.

Mercer established criteria to evaluate processes and systems employed by MCOs to collect, process, pay and audit the claims as well as send encounters to ASES. These criteria fall into specific categories and subcategories as depicted in the figure below.



Overall Assessment

Mercer reviewed and evaluated MCO data systems, processes, and staffing for the managing the claims intake, adjudication, and payment as well as extracting, transforming, and loading the data into the systems and engines for PM calculation and encounter submissions. Based on the documentation submitted and information gathered during the virtual reviews, Mercer identified strengths in the systems, operations, and capabilities as well as areas where MCOs could strengthen their processes.

FMHP

Strengths

- FMHP's implemented systems comply with the 42 CFR 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act and applied Strategic National Implementation Process (SNIP) edits levels 1–5, which strengthens the intake of claims processing and increases the quality of the data received.
- FMHP had processes and teams to monitor the quality of claims processing and audit the manually entered or processed claims to ensure high-quality data is used for payment, operations, and PM calculation.

Opportunities

- Although FMHP has adequate systems and processes in place to pay the claims, FMHP did not meet the required standard for timely payment of clean claims. It is recommended that FMHP complete a gap analysis to identify the deficiencies and address the existing limitations to ensure providers are paid on time.
- FMHP audit process is designed to focus on the manually processed claims, which account for about 6% of all claims (about 94% are auto adjudicated). Although the risk is inherently greater for the inaccurate payment for manually processed claim versus the auto adjudicated claims, the post-payment audit should not exclude auto-adjudicated claims. The post-payment audit should include a sample from the auto-adjudicated claims, in addition to the manually processed claims.

MMM

Strengths

- MMM's implemented systems comply with the 42 CFR 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act and has a comprehensive process for system changes and upgrades.
- MMM developed an island-wide initiative to visit providers and medical groups and ensure the providers comply with the encounter metrics. These efforts should result in better encounter submission to ensure each member visit has corresponding data. MMM used Relisc to analyze data, develop reports and dashboards for review and discussion with providers and medical groups.

Opportunities

- MMM staff's knowledge of SNIP levels, implementation and importance of SNIP levels could be enhanced to ensure alignment with the national standards and to confirm the EDI files are created properly and according to the Health Insurance Portability and Accountability Act (HIPAA) rules. It is recommended MMM complete a gap analysis to determine what level (if any) of SNIP edits are applied and to determine if any enhancements are necessary.
- Although MMM implemented processes to comply with most of the NIST 800-53 r4 system security, it is recommended MMM consider enhancing the security processes to align with the recognized standards and fully implement these standards.
- While MMM has P&Ps on the physical security, additional training to all employees and contractors, as well as reinforcement of the P&P, is recommended to strengthen MMM's physical security and mitigate the possibility of adverse exposure of data with sensitive and confidential information.

PSM

Strength

- PSM's implemented systems comply with the 42 CFR 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act. PSM implemented all seven levels of SNIP edits to ensure alignment with the national standards and to confirm the EDI files are created properly and according to the HIPAA rules.
- PSM audit processes include samples of no less than 2% and no more than 3% of the claims paid each week and focuses on high-complexity, high-dollar, override usage, and overall claims payment accuracy. PSM conducts additional special audits designed to support the claims, configuration and payment integrity, and cost savings operations. The robust audit processes are fundamental to ensuring the accuracy of the claims processing and payments as well as overall improvement in PI and claims operations.

Opportunities

- PSM staff stated that PSM does not use taxonomy codes. It is recommended that PSM review its P&Ps for collecting and using the taxonomy codes to align with CMS expectations. To receive an NPI, a provider must self-identify with at least one provider taxonomy code based on the National Uniform Claim Committee (NUCC). Therefore, all providers must have valid taxonomy codes.
- Although PSM has adequate systems and processes in place to pay the claims, PSM did not meet the required standard for timely payment of clean claims. It is recommended that PSM complete a gap analysis to identify the deficiencies and address the existing limitations to ensure providers are paid on time.

Triple S

Strengths

- Triple S' implemented systems comply with the 42 CFR 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act. Triple S implemented six levels of SNIP edits to ensure alignment with the national standards and to confirm the EDI files are created properly and according to the HIPAA rules.
- Triple S developed robust PowerBI dashboards used to assess monthly performance of overall inventory, paid and denied claims, adjustments, and more. Given that Triple S relied on Optum (vendor) to support claims activity, having a good monitoring tool is essential to ensuring timely claims payment and provider satisfaction.
- Incentives presented to providers or medical groups for encounter submission and close monitoring performed by Triple S ensures encounter data completeness.

Opportunities

- Triple S staff stated that it does not use taxonomy codes; It is recommended that Triple S review its P&Ps for collecting and using the taxonomy codes to align with CMS

expectations. To receive the NPI, the provider must self-identify with at least one provider taxonomy code based on the NUCC. Therefore, all providers must have valid taxonomy codes.

- Triple S sample size for claims audit is very small (202 claims out of over 4 million claims are audited). It is recommended that Triple S review its audit processes and determine appropriate sample size for audit of claims processed, paid, and denied. It is recommended that Triple S consider the use of random and stratified sampling techniques to account for daily manual and auto-processing of claims as well as sampling for claims that based on industry specific prior data are considered high risk such as third-party liability, high dollars, manually entered etc. to ensure accuracy of the payment.
- Triple S used two different data bases to produce encounter reports. The OneTSH is used to create extract for HEDIS reporting while QNXT is used for Puerto Rico Medicaid Management Information System reporting. Triple S reported no processes to validate data against each other. It is recommended that Triple S design and implement processes to regularly validate data in OneTSH against data in QNXT.

Section 6

Review of Compliance with Medicaid Managed Care Regulations

Introduction

To complete the review of compliance with Medicaid managed care regulations, Mercer utilized the mandatory compliance validation protocol (Protocol 3) to determine the extent to which MCOs and MAOs comply with federal standards set forth in 42 CFR 438, part 56, 100, 114, Subparts, QAPI, state standards, and MCO/MAO contract requirements. Below is a crosswalk of the standards reviewed by the EQRO to 42 CFR 438, the Subpart D and QAPI Standards.

Standard Reviewed by the EQRO	Subpart D and QAPI Standard
Enrollee Rights and Protections	§438.56 Disenrollment requirements and limitations
	§438.100 Enrollee rights requirements
Access and Availability	§438.206 Availability of Services
	§438.207 Assurances of Adequate Capacity of Services
Care Management	§438.208 Coordination and Continuity of Care
	§438.224 Confidentiality
Utilization Management	§438.210 Coverage and Authorization of Services
	§438.114 Emergency and post-stabilization services
	§438.236 Practice Guidelines
Provider Network	§438.214 Provider Selection
	§438.230 Sub-contractual Relationships and Delegation
Grievance and Appeals	§438.228 Grievance and Appeal Systems
Quality Improvement and Assessment	§438.242 Health Information Systems
	§438.330 QAPI

Review Process

To evaluate GHP and Platino plan compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of plan organizational charts, training

materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCOs and MAOs through the RFI and through on-site meetings held October 23–October 26, 2023 (Platino plans) and November 6–9, 2023 (GHPs). The on-site meetings involved participation from health plan key leadership including, but not limited to:

- Chief Executive Officer (CEO)
- Chief Medical Officer
- Chief Clinical Officer
- Senior Vice President (SVP) Clinical Affairs
- Assistant Vice President (AVP) Clinical Operations
- AVP Network Management
- AVP Service Operations
- VP Operations
- VP Compliance
- VP Claims
- VP Clinical Initiatives
- VP Medical Affairs
- VP QI
- Director, Delegation Oversight

Compliance Review Tools

Compliance review tools included detailed regulatory and contractual requirements in each standard area.

Per 42 CFR 438.360, Nonduplication of Mandatory Activities, it is not a part of the Puerto Rico Quality Strategy to receive the Platino Plans Medicare Quality Improvement Organization reports and review against the Medicaid EQR activities. Puerto Rico may consider this in the future for addition to the Quality Strategy for the Platino review cycle.

Compliance Review Results

The Appendices A and B provide the health plan-specific protocol 3 report sections, present the topics reviewed, the health plan team members who participated in the review, as well as the findings and recommendations. Summary results of the analysis make up this area of the report.

Scoring Methodology

For each regulatory/contractual requirement for each program, a three-point scoring system was used. Scores are defined in the following table.

Compliance Level Definitions	
Met	All required documentation is present, MAO/MCO staff provides responses that are consistent with each other and with the documentation, or documents and/or MAO/MCO staff provide evidence of compliance with regulatory or contractual provisions.
Partially Met	Any one of the following may be applicable: Section 1 Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided. MAO/MCO staff interviews, however, provided information that was not consistent with documentation provided. Section 2 Documentation to substantiate compliance with some but not all of the regulatory or contractual provision was provided although MAO/MCO staff interviews provided information consistent with compliance with all regulatory or contractual provisions. Section 3 Documentation to substantiate compliance with some but not all of the regulatory or contractual provision was provided, and MAO/MCO staff interviews provided information inconsistent with compliance with all regulatory or contractual provisions.
Not Met	No documentation is present and MAO/MCO staff have little to no knowledge of processes or issues that comply with regulatory or contractual provisions.

An overall percentage compliance score for each of the standards was calculated based on the total points scored divided by total possible points (Met = 3 point, Partially Met = 2 points, and Not Met = 1 points). In addition, an overall percentage compliance score for all standards was calculated to give each standard equal weighting. The total percentages from each standard were divided by the total number of standards reviewed. For each area identified as Partially Met or Not Met, the health plan was required to submit a CAP in a format agreeable to Puerto Rico.

GHP Compliance Validation Scores

The table below depicts the aggregate compliance scores for Puerto Rico's GHPs.

Standard Reviewed by the EQRO	Overall Compliance Rating	FMHP	MMM	PSM	Triple S
Enrollee Rights and Protections	§438.56 Disenrollment requirements and limitations	83%	67%	100%	100%

Standard Reviewed by the EQRO	Overall Compliance Rating	FMHP	MMM	PSM	Triple S
	§438.100 Enrollee rights requirements	75%	80%	75%	90%
Access and Availability	§438.206 Availability of Services	100%	100%	100%	63%
	§438.207 Assurances of Adequate Capacity of Services	100%	100%	100%	100%
Care Management	§438.208 Coordination and Continuity of Care	94%	83%	83%	89%
	§438.224 Confidentiality	100%	100%	100%	50%
Utilization Management	§438.210 Coverage and Authorization of Services	92%	92%	92%	92%
	§438.114 Emergency and post-stabilization services	50%	100%	100%	100%
	§438.236 Practice Guidelines	100%	100%	100%	100%
Provider Network	§438.214 Provider Selection	83%	83%	83%	100%
	§438.230 Subcontractual Relationships and Delegation	100%	100%	75%	100%
Grievances and Appeals	§438.228 Grievance and Appeal Systems	93%	89%	93%	93%
Quality Improvement and Assessment	§438.242 Health Information Systems	100%	100%	94%	100%
	§438.330 QAPI	100%	100%	100%	100%
MCO Average		**91%**	**92%**	**93%**	**91%**

Platino Plan Compliance Validation Scores

The table below depicts the aggregate compliance scores for Puerto Rico's Platino plans.

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	Humana	MCS	MMM Platino	Triple S Platino
Enrollee Rights and Protections	§438.56 Disenrollment requirements and limitations	100%	100%	100%	100%
	§438.100 Enrollee rights requirements	85%	90%	90%	90%
Access and Availability	§438.206 Availability of Services	75%	75%	100%	50%

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	Humana	MCS	MMM Platino	Triple S Platino
	§438.207 Assurances of Adequate Capacity of Services	100%	100%	100%	100%
Care Management	§438.208 Coordination and Continuity of Care	100%	100%	100%	50%
	§438.224 Confidentiality	100%	100%	100%	100%
Utilization Management	§438.210 Coverage and Authorization of Services	80%	80%	80%	100%
	§438.114 Emergency and post-stabilization services	50%	100%	100%	100%
	§438.236 Practice Guidelines	50%	100%	100%	100%
Provider Network	§438.214 Provider Selection	100%	100%	50%	100%
	§438.230 Subcontractual Relationships and Delegation	100%	100%	100%	100%
Grievances and Appeals	§438.228 Grievance and Appeal Systems	75%	93%	71%	93%
Quality Improvement and Assessment	§438.242 Health Information Systems	94%	100%	100%	100%
	§438.330 QAPI	100%	100%	100%	100%
MAO Average		**86%**	**96%**	**92%**	**92%**

Observations and Recommendations from Previous EQR

Mercer reviewed the last available Technical Report from the previous EQRO for the 2016–2017 review period. According to the report, Compliance Reviews were not conducted during that period, however the previous EQR provided recommendations from 2014–2015 review period and Health Plans provided responses to the 2014–2015 recommendations. As a part of the 2018–2022 RFI, Mercer requested CAPs from the health plans from the last review cycle, plans did not submit CAPS from the 2016–2017 period.

Of note, the health plans have changed from the 2016–2017 EQR review. PSM is a new plan for the current review period PSM, and Molina exited the PRMP in November 2020. FMHP, MMM, and Triple S remain in the program. There are four Platino Plans in this review that remain in the program, however 1 Platino plan, Constellation, exited the program prior to this review period.

Aggregate Health Plan Recommendations

There are not any recommendations from the 2016–2017 EQR period.

Health Plan-Specific Compliance Review Results

Mercer presents Health Plan CY 2022 Compliance Review results by individual health plan in this section. For detailed findings and recommendations for all MCOs/MAOs see Appendices A and B. Mercer used the technical scores along with qualitative review results to outline high-level strengths, findings, and recommendations.

GHPs

FMHP

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted an on-site review on November 6, 2023.

FMHP Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Overall Compliance Rating	Rate
Enrollee Rights and Protections	§438.56 Disenrollment requirements and limitations	83%
	§438.100 Enrollee rights requirements	75%
Access and Availability	§438.206 Availability of Services	100%
	§438.207 Assurances of Adequate Capacity of Services	100%
Care Management	§438.208 Coordination and Continuity of Care	94%
	§438.224 Confidentiality	100%
Utilization Management	§438.210 Coverage and Authorization of Services	92%
	§438.114 Emergency and post-stabilization services	50%
	§438.236 Practice Guidelines	100%
Provider Network	§438.214 Provider Selection	83%
	§438.230 Subcontractual Relationships and Delegation	100%
Grievances and Appeals	§438.228 Grievance and Appeal Systems	93%
Quality Improvement and Assessment	§438.242 Health Information Systems	100%
	§438.330 QAPI	100%
MCO Average		**91%**

MMM GHP

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted an on-site review on November 7, 2023.

MMM GHP Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Overall Compliance Rating	Rate
Enrollee Rights and Protections	§438.56 Disenrollment requirements and limitations	67%
	§438.100 Enrollee rights requirements	80%
Access and Availability	§438.206 Availability of Services	100%
	§438.207 Assurances of Adequate Capacity of Services	100%
Care Management	§438.208 Coordination and Continuity of Care	83%
	§438.224 Confidentiality	100%
Utilization Management	§438.210 Coverage and Authorization of Services	92%
	§438.114 Emergency and post-stabilization services	100%
	§438.236 Practice Guidelines	100%
Provider Network	§438.214 Provider Selection	83%
	§438.230 Subcontractual Relationships and Delegation	100%
Grievances and Appeals	§438.228 Grievance and Appeal Systems	89%
Quality Improvement and Assessment	§438.242 Health Information Systems	100%
	§438.330 QAPI	100%
MCO Average		**92%**

PSM

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted a virtual review on November 8, 2023.

PSM Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Overall Compliance Rating	PSM
Enrollee Rights and Protections	§438.56 Disenrollment requirements and limitations	100%

Standard Reviewed by the EQRO	Overall Compliance Rating	PSM
	§438.100 Enrollee rights requirements	75%
Access and Availability	§438.206 Availability of Services	100%
	§438.207 Assurances of Adequate Capacity of Services	100%
Care Management	§438.208 Coordination and Continuity of Care	83%
	§438.224 Confidentiality	100%
Utilization Management	§438.210 Coverage and Authorization of Services	92%
	§438.114 Emergency and post-stabilization services	100%
	§438.236 Practice Guidelines	100%
Provider Network	§438.214 Provider Selection	83%
	§438.230 Subcontractual Relationships and Delegation	75%
Grievances and Appeals	§438.228 Grievance and Appeal Systems	93%
Quality Improvement and Assessment	§438.242 Health Information Systems	94%
	§438.330 QAPI	100%
MCO Average		**93%**

Triple S GHP

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted a virtual review on November 9, 2023.

Triple S Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Overall Compliance Rating	Triple S
Enrollee Rights and Protections	§438.56 Disenrollment requirements and limitations	100%
	§438.100 Enrollee rights requirements	90%
Access and Availability	§438.206 Availability of Services	63%
	§438.207 Assurances of Adequate Capacity of Services	100%
Care Management	§438.208 Coordination and Continuity of Care	89%
	§438.224 Confidentiality	50%

Standard Reviewed by the EQRO	Overall Compliance Rating	Triple S
Utilization Management	§438.210 Coverage and Authorization of Services	92%
	§438.114 Emergency and post-stabilization services	100%
	§438.236 Practice Guidelines	100%
Provider Network	§438.214 Provider Selection	100%
	§438.230 Subcontractual Relationships and Delegation	100%
Grievances and Appeals	§438.228 Grievance and Appeal Systems	93%
Quality Improvement and Assessment	§438.242 Health Information Systems	100%
	§438.330 QAPI	100%
MCO Average		**91%**

Platino Plans

Humana

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted an on-site review on October 23, 2023.

Humana Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	Humana
Enrollee Rights and Protections	§438.56 Disenrollment requirements and limitations	100%
	§438.100 Enrollee rights requirements	85%
Access and Availability	§438.206 Availability of Services	75%
	§438.207 Assurances of Adequate Capacity of Services	100%
Care Management	§438.208 Coordination and Continuity of Care	100%
	§438.224 Confidentiality	100%
Utilization Management	§438.210 Coverage and Authorization of Services	80%
	§438.114 Emergency and post-stabilization services	50%
	§438.236 Practice Guidelines	50%
Provider Network	§438.214 Provider Selection	100%

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	Humana
	§438.230 Subcontractual Relationships and Delegation	100%
Grievances and Appeals	§438.228 Grievance and Appeal Systems	75%
Quality Improvement and Assessment	§438.242 Health Information Systems	94%
	§438.330 QAPI	100%
MAO Average		**86%**

MCS

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted an on-site review on October 24, 2023.

MCS Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	MCS
Enrollee Rights and Protections	§438.56 Disenrollment requirements and limitations	100%
	§438.100 Enrollee rights requirements	90%
Access and Availability	§438.206 Availability of Services	75%
	§438.207 Assurances of Adequate Capacity of Services	100%
Care Management	§438.208 Coordination and Continuity of Care	100%
	§438.224 Confidentiality	100%
Utilization Management	§438.210 Coverage and Authorization of Services	80%
	§438.114 Emergency and post-stabilization services	100%
	§438.236 Practice Guidelines	100%
Provider Network	§438.214 Provider Selection	100%
	§438.230 Subcontractual Relationships and Delegation	100%
Grievances and Appeals	§438.228 Grievance and Appeal Systems	93%
Quality Improvement and Assessment	§438.242 Health Information Systems	100%
	§438.330 QAPI	100%
MAO Average		**96%**

MMM Platino

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted an on-site review on October 25, 2023.

MMM Platino Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	MMM Platino
Enrollee Rights and Protections	§438.56 Disenrollment requirements and limitations	100%
	§438.100 Enrollee rights requirements	90%
Access and Availability	§438.206 Availability of Services	100%
	§438.207 Assurances of Adequate Capacity of Services	100%
Care Management	§438.208 Coordination and Continuity of Care	100%
	§438.224 Confidentiality	100%
Utilization Management	§438.210 Coverage and Authorization of Services	80%
	§438.114 Emergency and post-stabilization services	100%
	§438.236 Practice Guidelines	100%
Provider Network	§438.214 Provider Selection	50%
	§438.230 Subcontractual Relationships and Delegation	100%
Grievances and Appeals	§438.228 Grievance and Appeal Systems	71%
Quality Improvement and Assessment	§438.242 Health Information Systems	100%
	§438.330 QAPI	100%
MAO Average		**92%**

Triple S Platino

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted an on-site review on October 26, 2023.

Triple S Platino Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	Triple S Platino
Enrollee Rights and Protections	§438.56 Disenrollment requirements and limitations	100%

Standard Reviewed by the EQRO	Subpart D and QAPI Standard	Triple S Platino
	§438.100 Enrollee rights requirements	90%
Access and Availability	§438.206 Availability of Services	50%
	§438.207 Assurances of Adequate Capacity of Services	100%
Care Management	§438.208 Coordination and Continuity of Care	50%
	§438.224 Confidentiality	100%
Utilization Management	§438.210 Coverage and Authorization of Services	100%
	§438.114 Emergency and post-stabilization services	100%
	§438.236 Practice Guidelines	100%
Provider Network	§438.214 Provider Selection	100%
	§438.230 Subcontractual Relationships and Delegation	100%
Grievances and Appeals	§438.228 Grievance and Appeal Systems	93%
Quality Improvement and Assessment	§438.242 Health Information Systems	100%
	§438.330 QAPI	100%
MAO Average		**92%**

Section 7

2022 Quality Strategy Findings and Recommendations

Goal: 1. Improve Preventative Care Screening, Access to Care and Utilization of Health Services for all Plan Vital Enrollees

Mercer selected PMs from MY 22 to review a snapshot of preventive care screening, access to care, and utilization measures. Rates below that are at or above national average are reported in green.

Improve Preventative Care Screenings					
Childhood Immunization Status (CIS)	**FMHP Rates**	**MMM Rates**	**PSM Rates**	**Triple S Rates**	**EQRO Narrative and Suggestions for the State**
DTaP	10.2%	15.79%	10.4%	14.72%	All plans performed below the National Average for CIS. There is an EPSDT PIP in place to improve EPSDT screening rates. It is recommended that Puerto Rico review this PIP and add improvement of CIS rates as well as preventive visits. Puerto Rico may also consider provider and member outreach campaigns focusing on improving CIS and pediatric preventive visits.
Hepatitis A	61.3%	74.60%	68.1%	65.11%	
Hepatitis B	3.3%	3.51%	3.3%	5.33%	
HiB	32.4%	40.64%	29.9%	38.99%	
Influenza	6.9%	8.00%	11.1%	9.35%	
IPV	18.4%	21.49%	12.8%	21.67%	
MMR	57.4%	70.21%	61.8%	65.24%	
Pneumococcal Conjugate	9.8%	14.66%	10.1%	13.95%	
Rotavirus	8.9%	12.17%	7.4%	12.30%	
VZV	56.6%	67.32%	60.3%	65.31%	
Immunizations for Adolescents (IMA)	52.9%	59.33%	44.9%	54.27%	

Improve Access to Care					
	FMHP Rates	MMM Rates	PSM Rates	Triple S Rates	EQRO Narrative and Suggestions for the State
Prenatal and Postpartum Care Timeliness Prenatal Care	45.1%	66.42%	41.7%	84.37%	All plans performed below the National Average for CIS. There is an EPSDT PIP in place to improve EPSDT screening rates. It is recommended that Puerto Rico review this PIP and add improvement of CIS rates as well as preventive visits. Puerto Rico may also consider provider and member outreach campaigns focusing on improving CIS and pediatric preventive visits.
Prenatal and Postpartum Care Postpartum Care	21.8%	56.93%	31.2%	49.60%	
Improve Access to Care — Initiation and Engagement of Substance Use Disorder Treatment (IET)					FMHP had four measures and MMM had one measure that performed at or above the National Average. There is a significant variability across MCOs when reporting data. Given this variability, it is recommended Puerto Rico provide direction for reporting of measures.
IET Initiation (Total)	—	45.27%	—	—	
IET Initiation — Alcohol (Total)	—	—	—	29.54%	
13 Years–17 Years	0.0%	—	NA	—	
18 Years–64 Years	64.1%	—	32.2%	—	
65+ Years	62.5%	—	17.2%	—	
Initiation — Opioid (Total)	—	—	—	51.17%	
13 Years–17 Years	0.0%	—	NA	—	
18 Years–64 Years	89.1%	—	46.2%	—	
65+ Years	100.0%	—	25.0%	—	

Improve Utilization					
	FMHP Rates	MMM Rates	PSM Rates	Triple S Rates	EQRO Narrative and Suggestions for the State
Well-Child Visits in the First 30 months of Life (W30)					All Metrics are below National Average. There is an EPSDT PIP in place to improve EPSDT screening rates. It is recommended that Puerto Rico review this PIP and add preventive visits. Puerto Rico may also consider provider and member outreach campaigns focusing on pediatric preventive visits.
Age 15 Months	1.6%	11.67%	10.4%	6.74%	
Age 15 Months–30 Months	12.9%	44.15%	40.1%	36.34%	
Child and Adolescent Well-Care Visits (WCV)					All Metrics are below National Average. MCOs did not report the measures in the same way. Given this variability, it is recommended Puerto Rico provide clear reporting guidance and expectations for PMs.
3 Years–11 Years	17.5%	—	42.7%	46.13%	
12 Years–17 Years	14.3%	—	34.9%	38.92%	
18 Years–21 Years	7.2%	—	25.1%	25.75%	
Total	—	42.99%	—	39.05%	

Goal: 2. Improve Quality of Care and Health Services Provided to all Plan Vital Enrollees Through the HCHN Program

Puerto Rico has a HCHN program as a part of the Puerto Rico Health Care Improvement Program (HCIP). The HCIP provides payment incentives for improvement of selected measures. Mercer did not review the HCIP program as a part of the EQR activities. In its place Mercer is reviewing the PMs and PIPs that are condition specific and included in the HCIP.

Quality Strategy Expectation	EQRO Finding or HEDIS Rates				EQRO Narrative and Suggestions for the State
	FMHP	MMM	PSM	Triple S	
End State Renal Disease — *KED*					
18 Years–64 Years	—	—	14.1%	—	

Quality Strategy Expectation	EQRO Finding or HEDIS Rates				EQRO Narrative and Suggestions for the State
	FMHP	MMM	PSM	Triple S	
65 Years–74 Years	—	—	13.9%	—	There was significant variability across MCOs when reporting data. Given this variability, it is recommended Puerto Rico provide direction for reporting of measures. Of note, Puerto Rico has modified the ESRD related PIP for 2023 to to include kidney health evaluation rates in order to identify early stages of decreased kidney function. It is required in the PIP to use HEDIS measure Kidney Health Evaluation for patients with diabetes (KED).
75 Years–85 Years	—	—	15.4%	—	
Total	12.7%	18.55%	—	17.85%	
End State Renal Disease — *PIP* *One clinical care project in the area of increasing fistula use for Enrollees at risk for dialysis*	Moderate confidence	Moderate confidence	Low confidence	Low confidence	Two of the four MCOs received Moderate confidence for this PIP. The PIP has been modified in 2023 to include kidney health evaluation rates to identify early stages of decreased kidney function.
Children and Youth with SHCNs/Autism Populations — *PIP* *One administrative project in the area of EPSDT*	Low confidence	Low confidence	Low confidence	Moderate confidence	Triple S was the only plan to receive a moderate confidence score for EPSDT; all others were scored low confidence. It is recommended Puerto Rico consider developing specificity for measures to achieve tangible results and ensure metrics and data collection procedures are clearly defined.
Colorectal Screening					All MCOs performed below the National Average for this measure. It is recommended for Puerto Rico to consider using provider and member outreach campaigns to improve screenings. There was significant variability across MCOs when reporting data. Given this variability, It is recommended Puerto Rico provide direction for reporting of measures.
46 Years–49 Years	24.1%	—	22.6%	29.92%	
50 Years–75 Years	38.7%	—	45.2%	46.59%	
Total	—	44.93%	—	43.44%	
Brest Cancer Screening	56.0%	62.01%	70.8%	65.14%	All MCOs performed at or better than the National Average for this measure.

Quality Strategy Expectation	EQRO Finding or HEDIS Rates				EQRO Narrative and Suggestions for the State
	FMHP	MMM	PSM	Triple S	
Cervical Cancer Screening	42.4%	50.38%	51.3%	46.01%	All MCOs performed below the National Average for this measure. It is recommended for Puerto Rico to consider using provider and member outreach campaigns to improve screenings.

Goal: 3. Improve Enrollee Satisfaction with Provided Services and Primary Care Experience

Mercer reviewed the MCO 2022 the Consumer Assessment of Healthcare Providers and Systems (CAHPS). CAHPS surveys are sent out randomly to Enrollees to rate their health plan satisfaction with several preselected measures. A total of six (three Adult and three Child) Enrollee survey responses covering satisfaction with personal doctor, all healthcare, and health plan are displayed below. CAHPs that scored at or above the 90th percentile are reported in green.

FMHP and PSM performed in the 90th percentile for all measures. MMM met three out of six measures at the 90th percentile, while Triple S met the 90th percentile for one out of six measures. It is recommended for Puerto Rico to review the Health plans with lower CAHPS ratings and get information of how the plans are responding to the annual CAHPs surveys and planned interventions focused on improvement.

Quality Strategy Expectation	EQRO Finding or HEDIS Rates			
	FMHP	MMM	PSM	Triple S
CAHPS Rating of Personal Doctor	Adult 88.1% Child: 91.5%	Adult: 79.0% Child: 69.8%	Adult: 91.2% Child: 92.6%	Adult: 66.7% Child: 74.4%
CAHPS Rating of All Healthcare	Adult: 82.7% Child: 93.2%	Adult: 70.0% Child: 67.9%	Adult: 86.3% Child: 88.6%	Adult: 52.3% Child: 64.7%
CAHPS Rating of Health Plan	Adult: 87.3% Child: 89.2%	Adult: 71.7% Child: 62.7%	Adult: 88.7% Child: 85.7%	Adult: 70.3% Child: 64.7%

Section 8
Network Adequacy Evaluation

EQR Objectives

The PRMP requested Mercer conduct an evaluation of provider network access for the new MCO Plan Vital 2023 contract, including identification of opportunities for improvements and recommendations to address network gaps and updates to program requirements. The 2023 Plan Vital program includes contracts with the four Medicaid MCOs: FMHP, MMM, PSM, and Triple S. The objective of this analysis is to review the MCO network adequacy standards based on the 2023 Puerto Rico Medicaid Vital contract to assess MCO compliance. The 2023 Plan Vital program requires time and distance standards in compliance with the Federal and Government of Puerto Rico network adequacy requirements set forth in 42 CFR § 438.68 and MCO contracts.

Technical Data Collection

To address this request, Mercer evaluated MCO performance against the contract year 2023 network adequacy contract standards, added 2023 network questions and supporting document requests to the RFI, and created a summary of findings and recommendations. MCOs were asked to provide a variety of information, including P&Ps, reports such as geo-access and appointment availability, and share contracted Network provider information for the most recent quarter ending on June 30, 2023.

Mercer reviewed MCO completed RFIs, supporting documentation and reports to evaluate network adequacy and compliance with the 2023 Plan Vital contract Section 9. The MCO self-reported data within the RFI and report submissions are the primary source of information for measuring network adequacy against Plan Vital contract standards. Each Network Adequacy requirement is scored as Met, Not Met, or Met by Exception in the following tables. MCOs may request an exception for approval by ASES in the event they cannot meet a Network Adequacy Standard.

Example of Rating Scale

Example Standard	Plan A	Plan B	Plan C	Plan D
PCP time and distance requirement	Not Met	Met by Exception	Not Met	Met

Data Analysis and Conclusions

Network Adequacy Standards

In 2023, the Puerto Rico Network Adequacy Standards in the Plan Vital contract include:

- Provider-to-Enrollee Ratios
- Provider Per Municipality Requirements
- Required Network Provider Requirements
- Time and Distance Requirements

All standards were developed in accordance with 42 CFR 438.68, as defined by ASES in Section 9.4 to measure the adequacy and appropriateness of the MCO's provider network to meet the needs of the enrolled population.

The MCOs must maintain an island-wide provider network that complies with the Network Adequacy Standards specified in Section 9.4 of the contract, use geographical access and thermal mapping, and always provide adequate access to Enrollees. As mentioned above, the MCOs may request an exception for approval by ASES in the event they cannot meet a Network Adequacy Standard. The request must provide detailed information justifying the need for an exception and actions underway to meet compliance. The exception does not relieve the MCO from remedying non-compliance with defined Network Adequacy Standards within a reasonable timeframe or complying with a Corrective Act Plan established in collaboration with ASES. All plans were asked to provide a list of approved Network exceptions in place for 2023.

2023 Total Number of Contracted Providers

Standard(s)	FMHP	MMM	PSM	Triple S
PCP	2,424	2,030	1,443	1,719
PMG	115	98	84	85
Hospital	68	43	80	53
Urgent Care	99	85	6	13
Nursing Facility	1	3	1	80
Dental	538	970	635	3
Vision	296	591	297	826
BH	1176	831	1132	114
Federally Qualified Health Center (FQHC)	8	21	19	1176

Findings

Mercer utilized network accessibility reports and geo maps where applicable to gather the data in the table above. In some cases, no other source of information was available beyond what was submitted by the MCO in the RFI and some data appears to vary greatly. For example, Triple S indicated they have 80 nursing facilities, while other plans report only 1–3 nursing facilities. This may be due to a report on the number of beds instead of the number of facilities. Similarly, Triple S reported 826 vision providers, while the other plans report 591 or less. All the plans reported a wide variation on the volume of urgent care providers, with FMHP and MMM reporting 99 and 85, respectively and PSM and Triple S reporting 6 and 13,

respectively. For these examples and others, follow-up is recommended to determine the reason/s for the variability.

Recommendations

As noted in the findings, some of the reported numbers of providers vary. A root cause analysis of the reasons for the variations in numbers between plans is recommended to determine if the variation is due to different definitions of provider types or different methodologies for capturing information. At a minimum, a clear definition of how to measure each type of provider should be provided. Examples include denoting if facilities should be reported by number of beds or the overall structure, if a group practice should be counted once for the entire practice, or if each practitioner in the group practice should be counted individually. A base definition of provider types may also be useful so that all plans have the same understanding of what constitutes an urgent care or vision provider.

PCP Provider-to-Enrollee Ratios

Standard(s)	FMHP	MMM	PSM	Triple S
PCP 1:1,700 (Enrollees 21 years and older)	Met	Met	Met	Met
Gynecologist as PCP 1:2800 (Female Enrollees 12 years and older)	Met	Met	Met	Met

Hospital Provider-to-Enrollee Ratios

Standard(s)	FMHP	MMM	PSM	Triple S
Hospital 1:50,000 Enrollees	Met	Met	Met	Met

Provider Per Municipality Requirements

Standard(s)	FMHP	MMM	PSM	Triple S
At least two Adult PCPs and one Pediatric PCPs, in each municipality	Met	Met	Met	Met by Exception — Adults in Florida, Vieques, Culebra. Met by Exception — Pediatric in Florida
At least one Psychiatrist, Psychologist, Licensed Clinical Social Worker, or other Licensed BH Provider in each municipality	Met	Met by Exception in Ceiba	Met	Met

Findings

All MCOs Met or Met by Exception for the standards within the Provider Per Municipality Requirements. Vieques and Culebra are islands where provider recruitment is challenging. It should be noted that Vieques and Culebra have been identified by Puerto Rico as areas requiring special attention. The contract does provide for “Preferential Turns” for residents of these municipalities, where Enrollees from these islands are able to be seen in a priority order due to the distance they are required to travel.

Recommendations

It appears some MCO exceptions have not been updated since 2018; therefore, it is recommended that Puerto Rico annually review the exception requests from the plans to determine if plans have been making efforts to fill gaps where possible. Potential options to address existing gaps may include evaluating alternative payment arrangements to determine whether they have been successful in retaining providers.

Required Network Providers

The Puerto Rico 2023 Plan Vital Contract 9.6 defines the required Government Healthcare facilities MCOs must have in their general network. These nine hospitals are:

- Hospital Universitario Ramón Ruiz Arnau
- Hospital Universitario de Adultos
- Hospital Federico Trilla
- Hospital Pediátrico Universitario
- Centro Cardiovascular de PR y del Caribe
- Administración de Servicios Médicos de Puerto Rico
- Comprehensive Cancer Center of Puerto Rico (Centro Comprensivo de Cancer)
- Práctica Intramural del Recinto de Ciencias Médicas of the University of Puerto Rico operating at any hospital facility
- Hospital Municipio de San Juan

In Section 9.7 of the Plan Vital Contract, it defines the hospital with psychiatric beds that must be included in the MCO network.

The required four psychiatric hospitals include:

- Hospital Dr. Ramón Fernández Marina, San Juan
- Hospital San Juan Capestrano
- Hospital Metropolitano Psiquiátrico, Cabo Rojo
- Hospital Panamericano, Cidra

The eight hospitals with dedicated psychiatric beds that must be in the General Network include:

- Metro Pavía, Hato Rey
- San Jorge Children and Women's, San Juan
- Hospital Menonita CIMA, Aibonito
- Hospital Metropolitano de la Montaña, Utuado
- Hospital Pavía Yauco, Tito Mattei
- Hospital Panamericano San Juan (Auxilio Mutuo)
- Hospital Univ. Dr. Federico Trilla, Carolina
- Hospital San Lucas, Ponce

Required Network Provider Facilities

Standard(s)	FMHP	MMM	PSM	Triple S
FQHC One (1)	Met	Met	Met	Met
All Government Healthcare Facilities (9)	Not Met (reported met and 8 facilities)	Met (reported 10 facilities)	Met	Not Met (reported met and 7 facilities)
All Psychiatric Hospitals 12 (4 psychiatric, 8 with psychiatric beds)	Met	Met (reported 13)	Met (reported 13)	Met by Exception (reported 11 out of 10)
Available emergency stabilization units	Met (11 reported)	Met (9 reported)	Met (11 reported)	Met (reported 11 out of 10 available)
Available psychiatric partial hospitalization facilities	Not Met (reported 28 of 32)	Not Met (reported 34 of 35)	Not Met (reported 28 out of 32)	Not Met (reported 26 of 30)

Findings

There is an inconsistency with the MCOs reporting of the available number of facilities. For example, all Government Healthcare Facilities have a total number of nine available facilities in the contract. Each MCO reported the available number differently as 7, 8, 9, or 10 available facilities. The same reporting inconsistency exist with the metric for All Psychiatric Hospitals which have 12 available facilities in the contract. Three out of four MCOs list 11 or 13 available facilities.

For the measure of available emergency stabilization units, the contract does not name the facility or number of available facilities. All MCO reported they had met the standard, however the number of reported contracted facilities ranged from 9 to 11.

All plans reported they were contracted with less than the total number of available psychiatric partial hospitalization facilities. However, there is not a defined number of facilities or named facilities in the contract. For this metric all MCOs are rated as Not Met as the reported contracted facilities is less than the reported available facilities.

Recommendations

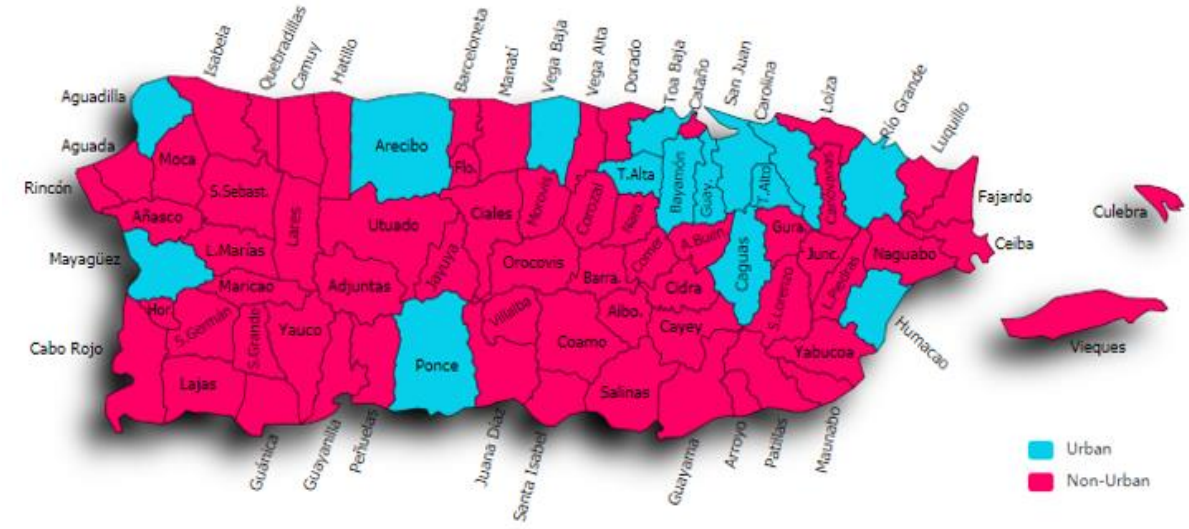
Mercer used the quarterly reports that include an attestation to review the required providers in the network. The report does not match the number of required providers in the contract and the MCOs are self-reporting the standards as met or not met. There are however discrepancies with the number of required facilities and the number contracted. It is recommended for Puerto Rico to update this report to highlight contracts with required facilities or by name of the facility to note which facilities the MCOs have not contracted with. There may also be a need for an additional metric for MCOs to report contracts with additional facilities providing service types other than the facilities names in the contract.

It is also recommended that Puerto Rico review and adjust the score as appropriate for the MCOs self-reported as Met or not Met rather than keeping the current self-reported process. There is also an opportunity for Puerto Rico to list the number of available emergency stabilization units and psychiatric partial hospitalization facilities in the contract. Each MCO is reporting different numbers of both available and contracted facilities. Without having a standard number and identified facilities this is not a metric that can be easily verified as being met.

Time and Distance Requirements

Section 9.4.4 of the contract specifies time and distance standards required in MCO networks. Puerto Rico defines urban municipalities with populations of 50,000 persons or more and non-urban municipalities with populations with 49,999 persons or less. Out of the 78 municipalities, 15 are considered urban based (see Urban versus Non-Urban Municipalities below). Urban municipalities include Aguadilla, Arecibo Bayamón, Caguas, Carolina, Guaynabo, Humacao, Mayagüez, Ponce, Río Grande, San Juan, Toa Alta, Toa Baja, Trujillo Alto, and Vega Baja.

Urban versus Non-Urban Municipalities[3]



The 2023 Plan Vital contract defines Adult and Pediatric High Volume Specialty Care Providers to be included in the time and distance standards. Adult High Volume Specialty Care Providers for purposes of Time and Distances standards are Cardiology, Endocrinology, Oncology, Nephrology, and Pulmonology. The Pediatric High Volume Specialty Care Providers for purposes of Time and Distance standards are Cardiology, Endocrinology, Oncology, Pulmonology, and Speech, Language, and Hearing.

Time and Distance Standards

Standard(s)	FMHP	MMM	PSM	Triple S
PCP — Adult Urban/Non-Urban: at least two PCPs within 15 miles/30 minutes	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met by Exception in Culebra and Vieques
PCP — Pediatric Urban/Non-Urban: at least two PCPs within 15 miles/30 minutes	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met by Exception Non-Urban: Met by Exception in Vieques
PCP — OB/GYN Urban/Non-Urban: at least two OBGYNs	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met by Exception in	Urban: Met Non-Urban: Met	Urban: Met by Exception

[3] Source: United States Census Bureau, 2019.

Standard(s)	FMHP	MMM	PSM	Triple S
within 15 miles/30 minutes		Culebra and Vieques		Non-Urban: Met by Exception in Vieques
High Volume Specialty Care Provider — Adult Urban: one of each type within 30 miles/60 minutes Non-Urban: one of each type within 45 miles/90 minutes	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met
High Volume Specialty Care Provider — Pediatric Urban: one of each type within 30 miles/60 minutes Non-Urban: one of each type within 45 miles/90 minutes	Urban: Met by Exception for Endocrinology and Oncology Non-Urban: Met by Exception for Cardiology, Endocrinology, and Oncology	Urban: Met by Exception for Endocrinology, Oncology, and Pulmonology Non-Urban: Met by Exception for Endocrinology, Oncology, and Pulmonology	Urban: Met by Exception for Cardiology and Oncology Non-Urban: Met by Exception for Cardiology and Oncology	Urban: Met Non-Urban: Met
Adult and Pediatric Dental Providers Urban: one of each type within 30 miles/60 minutes Non-Urban: one of each type within 45 miles/90 minutes	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met
Adult and Pediatric MH Providers-Psychologist Urban/Non-Urban: at least one within 15 miles/30 minutes	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met
Adult and Pediatric MH Providers-Psychiatrist Urban/Non-Urban: at least one within 15 miles/30 minutes	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met

Standard(s)	FMHP	MMM	PSM	Triple S
Adult and Pediatric MH Providers- Licensed Clinical Social Worker or Licensed Professional Counselor Urban/Non-Urban: at least within 15 miles/30 minutes	Urban: Met Non-Urban: Met by Exception in Culebra and Vieques	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met by Exception in Culebra	Urban: Met Non-Urban: Met
Adult and Pediatric Substance Use Disorder (SUD) Providers — Detoxification and rehabilitation Non-Urban: at least one within 45 miles/90 minutes	Non-Urban: Met by Exception for Emergency Stabilization Units and Psychiatric Hospitals in Culebra and Vieques	Non-Urban: Met by Exception for Emergency Stabilization Units and Psychiatric Hospitals in Culebra and Vieques	Non-Urban: Met	Non-Urban: Met by Exception for Emergency Stabilization Units and Psychiatric Hospitals in Culebra and Vieques
Adult and Pediatric SUD Providers — Intensive Outpatient (IOP) or Partial Hospitalization (PHP) Urban: at least one 30 miles/60 minutes, Non-Urban: at least one within 45 miles/90 minutes	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met
Hospitals Urban: one Hospital within 30 miles/60 minutes. Non-Urban: one Hospital within 45 miles/90 minutes	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met
Emergency Room (either Hospital or Freestanding) Urban/Non-Urban: one Emergency Room within 20 miles/30 minutes	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met	Urban: Met Non-Urban: Met by Exception in Culebra

Findings

All time and distance standards are Met or Met by exception for all MCOs.

Recommendations

It is recommended for Puerto Rico to define time and distance in their contract to include the detail of “driving distance or as the crow flies”. It is recommended to review and update report 16 to include the required elements of the network standards and remove areas that are no longer required for this contract period. Review exception requests and create an approval process on an annual basis to review efforts made by plans to contract with new providers. The exception requests submitted by the other three plans noted that either no providers were available, or all available providers were contracted but the number of providers was insufficient. Many of the exception approvals submitted were dated 2018 and should be reviewed to ensure that the reason for the exception is still valid or if the exception is still required. In some cases, such as adult and pediatric MH providers, the use of telehealth may be explored to see if telehealth may assist in increasing network adequacy.

The two areas consistently noted to be Met by Exception were in pediatric urban and non-urban specialties and for providers in Culebra and Vieques. The types of pediatric specialists Met by Exception were not consistent across all plans, suggesting some providers are not contracting with all plans. The reporting of this item should be further explored. A review of contracted providers would help determine if some providers could be recruited to contract with all plans and not just one or two. In addition, review of private providers that may be available to provide Medicaid services in the exception areas noted could provide another potential area of recruitment to expand the available network.

Network Development Efforts

Findings

There is not a consistent reporting from the MCOs. Some MCOs provided a network development and evaluation plan while another provided a narrative and not a formal document.

Recommendations

It is recommended for Puerto Rico to standardize the reporting requirements in the annual Network Development and Evaluations to include information such as a detailed summary of annual recruitment, retention, terminations, oversight and monitoring, and review of current network exceptions, and any identified gaps in service. The plan and evaluation can also be used more widely across to review member grievances and appeals to review access related issues.

Appointment Access and Availability

MCO Oversight and Monitoring

The Plan Vital MCO contract outlines oversight and monitoring activities that the MCOs must complete. Mercer requested the policies, procedures, and most recent 2023 audits to review compliance with the contract standards and monitoring activities.

PCP Ratio Review

The 2023 Plan Vital contract (9.4.3.1.4) stipulates that “on a monthly basis, the Contractor must review Enrollment Counselor PCP assignments to ensure ratios do not exceed the ratio requirements defined in Sections 9.4.3.1.2 and 9.4.3.1.3. In the event the Contractor assigns Enrollees to a PCP that exceeds the stated Provider-to-Enrollee Ratio requirement, the Contractor must obtain prior written approval for an exception from ASES to continue to assign Enrollees to the PCP”. The MCOs were asked to provide the P&Ps and the most recent monthly enrollment counselor audit of PCP assignment.

Findings

All MCOs reported they do not review the Enrollment Counselor PCP assignments monthly as required in the contract.

Recommendations

It is recommended for Puerto Rico to review and revise their contract as necessary or (if this process to review provider enrollment still falls to the MCOs as a responsibility) to meet and discuss this contract requirement with the MCOs. It is recommended to develop a process to review and audit PCP enrollment ratios, develop specific templates for MCOs to follow. Consider performing a per provider, complete Medicaid enrollment review to see how many Medicaid Enrollees are assigned per provider and not just per MCO.

Provider Access and Appointment Availability

The MCOs were also asked to provide the P&P for the review of provider appointment availability as well as their most recent quarter provider appointment availability audit. Below is the table of contract year 1 (2023) MCO required Provider audits by quarter. Each MCO is required to audit 25% of their contracted providers in the assigned provider types to review appointment availability and timeliness, provider contact information (address, phone, email and fax numbers), open/closed panel status and identify providers accepting new patients, disability access, equipment, or limitations and languages spoken and culturally specific training. Mercer reviewed MCO policies as well as the MCO 2023 Quarter 2 audit findings.

MCO Quarterly Provider Audit Assignments

MCO	Q1	Q2	Q3	Q4
FMHP	Specialists — Pediatric	Specialists — Adult	PCP — Pediatric	PCP — Adult
MMM	PCP — Adult	Specialists — Pediatric	Specialists — Adult	PCP — Pediatric
PSM	PCP — Pediatric	PCP — Adult	Specialists — Pediatric	Specialists — Adult
Triple S	Specialists — Adult	PCP — Pediatric	PCP — Adult	Specialists — Pediatric

Findings

All plans reported that they do an audit of appointment standards through a review of their geo access maps and a quarterly survey of a percentage of their providers for compliance with Section 9.3 of their contract, including elements such as validation of demographic information, handicap accessibility, service hours, spoken language, whether the provider is accepting new patients, and timeliness standards for routine and crisis care. The plans do collect G&A reports and member satisfaction surveys but do only report quarterly on the 25% of the provider type selected for any potential issues. It is not known what happens for other provider types that have had a complaint or grievance during the reporting timeframe.

Recommendations

Report 17 provides a section (17.E) for MCOs to provide details of remediations for any findings. It was found none of the MCOs provided details of the oversight and management or mitigation of their findings. It is recommended that Puerto Rico ensure that the MCOs are completing the reports with narrative details as required in the report template to provide details on what actions are put into place to ensure there is appointment access and availability.

It is recommended to review the provider access monitoring requirements and consider adding a list of complaints and grievances related to access and availability of providers for all provider types quarterly by MCO. It is recommended for Puerto Rico to add secret shopper surveys as oversight and monitoring to ensure providers are meeting appointment standards. ASES may want to add an assessment for Preferential Turns to validate information beyond provider self-report. It is also recommended to review the annual member satisfaction surveys to review for potential access issues.

Section 9
Program Integrity

EQR Objectives

Mercer conducted a review of the Puerto Rico PI compliance with regulatory and contractual responsibilities for CY 2022 to Quarter 2 2023 (June 30, 2023) for the current MCO/MAOs. PI focuses on the activities each health plan is conducting to ensure state and federal taxpayer dollars are spent appropriately on delivering quality, necessary care, and preventing fraud, waste, and abuse (FWA).

The evaluation analyzed MCP operations for the following 11 PI standards:

- Standard 1 Written P&Ps
- Standard 2 Corporate Staffing
- Standard 3 Training
- Standard 4 Communication
- Standard 5 Disciplinary Guidelines
- Standard 6 Claims Monitoring and Recoupment Process
- Standard 7 Auditing (Provider Compliance Reviews)
- Standard 8 Response to Offenses
- Standard 9 Member Verification
- Standard 10 Payment Suspension and Excluded Providers
- Standard 11 Report Submittal and Compliance with Contractual Obligations

Data Collection and Analysis

The MCPs supplied documentation in response to a RFI for PI. Mercer received information from the RFI electronically and reviewed the documents submitted. The Mercer review team interviewed each health plan during on-site or virtual meetings, asking questions of the personnel who have responsibility for the organizations' PI efforts. Information was gathered, and a comprehensive analysis was completed. This analysis was incorporated into a PI report.

General Findings and Recommendations

The following represents the key strengths and opportunities noted during the evaluation process.

Strengths

- The compliance teams Mercer met with on-site were passionate about the work they do and genuinely interested in the PI of their plans. PI staffing was adequate for all health plans. Some plans had dedicated Puerto Rico staff, while others relied on staff outside of Puerto Rico to conduct investigations and PI-related activities. Both approaches can be sufficient and may be needed to ensure timely compliance with contractual requirements.
- Whistleblower protections were strong in all plans. These protections help ensure that employees will communicate freely when they report potential FWA. This ultimately helps the health plans become better stewards of their resources and excellent providers of care to their members.
- Effective lines of communication between Compliance Officers and employees exist for almost all plans. Regular meetings throughout the year are held by the Compliance Officer with employees about various PI and FWA topics.
- Disciplinary guidelines and enforcement are critical for a strong compliance program. All plans demonstrated their guidelines are thorough and clear, and almost all plans were able to confirm these guidelines were well-publicized.
- Methods and criteria for identification, investigation, and referral of FWA are robust across all health plans. Compliance with Stark Law is present and notifying agencies of investigations was in place for almost all plans.
- All health plans are providing their quarterly FWA reports as required. This reporting is a key tool for PRMP to conduct its PI activities.

Opportunities

- Some of the Platino plans did not seem to understand their Medicaid responsibilities, as providers of Medicaid wrap-around services and recipients of Medicaid funding. Mercer recommends Puerto Rico have additional communication and discussions with the Platino plans to reduce this misunderstanding.
- All health plans had at least one finding in the standard of Payment Suspension and Excluded Providers. This standard examines whether payments are suspended when there is a credible allegation of fraud. The standard also covers processes around collecting provider disclosures related to ownership or affiliation, risk assessments, and provider terminations. There are many requirements in this standard, as well as nuances to the regulation language which may be difficult to understand. Mercer recommends additional education of health plans and providers on this PI standard.
- Claims monitoring and claims auditing are areas where more work could be done by all plans to improve FWA identification, prevention, and recoupment. Fraudulent schemes continue to change and become more difficult to discover. Mercer recommends plans increase the volume of claims monitored and audited.
- It was unclear if all health plans review trends for all monitoring and auditing activities related to FWA. Reporting and reviewing trends over time can be extremely valuable in

detecting FWA. Mercer recommends plans display trends in regular reports and make the reporting and review of these trends part of their P&Ps.

- As the responsibilities of PRMP and Administración de Seguros de Salud de Puerto Rico (ASES) evolve over time, it is important health plans contract requirements are updated as well. It is recommended that health plans contracts be reviewed periodically to confirm requirements, statements about agency activities such as agency responsibilities, notification to agencies, etc. are accurate and complete.

GHP Findings and Recommendations

Below is a high-level summary of findings for the MCOs by standard.

Standard	FMHP	MMM	PSM	Triple S
Written P&Ps	Met	Met	Partially Met	Partially Met
Corporate staffing	Met	Met	Met	Met
Training	Met	Partially Met	Partially Met	Met
Communication	Met	Met	Partially Met	Met
Disciplinary guidelines	Met	Met	Met	Met
Claims monitoring and recoupment process	Met	Met	Partially Met	Partially Met
Auditing (provider compliance reviews)	Met	Met	Met	Met
Response to offenses	Met	Met	Met	Met
Member verification	Met	Met	Met	Met
Payment suspension and excluded providers	Partially Met	Partially Met	Partially Met	Partially Met
Report submittal and compliance with contractual obligations	Met	Met	Met	Met

Platino Findings and Recommendations

Below is a high-level summary of findings for the MAOs by standard.

Standard	Humana	MCS	MMM Platino	Triple S Platino
Written P&Ps	Partially Met	Met	Partially Met	Partially Met
Corporate staffing	Met	Met	Met	Met
Training	Met	Met	Met	Met
Communication	Met	Met	Met	Met
Disciplinary guidelines	Met	Met	Met	Partially Met
Claims monitoring and recoupment process	Partially Met	Partially Met	Partially Met	Met

Auditing (provider compliance reviews)	Met	Met	Partially Met	Met
Response to offenses	Partially Met	Met	Partially Met	Met
Member verification	Partially Met	Met	Partially Met	Met
Payment suspension and excluded providers	Partially Met	Partially Met	Partially Met	Partially Met
Report submittal and compliance with contractual obligations	Met	Met	Met	Met

Appendix A
Review of Compliance with Medicaid Managed Care Regulations for GHPs

Introduction

To complete the review of compliance with Medicaid managed care regulations, Mercer utilized the mandatory compliance validation protocol (Protocol 3) to determine the extent to which MCOs comply with federal standards set forth in 42 CFR 438, part 56, 100, 114, Subparts D and Quality Assessment and Performance Improvement (QAPI), State standards, and MCO contract requirements. Below is a crosswalk of the standards reviewed by the EQRO.

Standard Reviewed by the EQRO	Subpart D and QAPI Standard
Enrollee Rights and Protections	§438.56 Disenrollment requirements and limitations
	§438.100 Enrollee rights requirements
Access and Availability	§438.206 Availability of Services
	§438.207 Assurances of Adequate Capacity of Services
Care Management	§438.208 Coordination and Continuity of Care
	§438.224 Confidentiality
Utilization Management	§438.210 Coverage and Authorization of Services
	§438.114 Emergency and post-stabilization services
	§438.236 Practice Guidelines
Provider Network	§438.214 Provider Selection
	§438.230 Sub-contractual Relationships and Delegation
Grievance and Appeals	§438.228 Grievance and Appeal Systems
Quality Improvement and Assessment	§438.242 Health Information Systems
	§438.330 QAPI

FMHP

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of FMHP's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through on-site meetings held November 6, 2023. The on-site meetings involved participation from MCO key leadership including, but not limited to:

- SVP of Clinical Affairs
- VP of Medical Affairs
- VP of Regulatory Affairs
- Enrollment Director
- Enrollee Services Director
- Corporate Compliance Director
- Compliance and Quality Director
- Network Contracting and Provider Services Director
- Credentialing Director
- Provider Network Director
- Senior Medicaid Director
- UM Director
- UM Director, APS
- Director of Clinical Operations

Strengths

FMHP presented with strong leadership and passion for their Enrollees, consistently monitoring the network to ensure access is available for Enrollees.

FMHP has a strong strategic PM reporting team specializing in efficient data collection capabilities, report analysis, timely problem solving, and knowledge of any new industry standards.

Opportunities for Improvement

FMHP has clear documentation about provider terminations but is lacking verification of reports being submitted to ASES when no action is taken against providers.

FMHP has the opportunity to enhance the PIP Aim Statements by clearly stating the improvement strategy, target population, measurable impact, and time period within each PIP structures as well as demonstrate continuous QI techniques within the PIP evaluation process.

Although FMHP has adequate systems and processes in place to pay the claims, FMHP did not meet the required standard for timely payment of clean claims.

Recommendations

It is recommended FMHP update provider termination and reporting policies to verify reports are submitted to ASES showing when no action is taken against providers.

It is recommended FMHP develop PIP Aim Statements that are clear, concise, measurable, and answerable, as well as adopt and implement continuous QI methodologies with the PIP process.

It is recommended FMHP complete a gap analysis to identify the deficiencies and address the existing limitations to ensure providers are paid on time.

Administration and Organization

Overview

Organizational Structure

FMHP's organizational structure includes a Board of Directors composed of seven members and a chairperson, and an executive team responsible for managing administrative policies and decisions. The FMHP president works closely with the Board of Directors to set goals, plans, and strategies and has oversight of First Medical (FM) Salud Inc. (an affiliated entity responsible for delegated tasks). The FM Salud VP and Director positions report to the Administrative President for the GHP Vital line of business. The SVP of Administration for FMHP reports to the President and has oversight of the VP and director positions. The Chief Medical Officer (CMO) is responsible for providing medical leadership, strategic guidance, and oversight of clinical and medical affairs.

FMHP currently has approximately 700 employees and 20 service offices throughout Puerto Rico, serving approximately 600,000 members. FMHP offers Medicaid and Commercial lines of business.

Delegated Entities

FMHP delegates responsibilities to seven different entities outlined in the table below.

Delegated Entity	Type of Entity and Services
APS Healthcare of Puerto Rico	MH — MH benefits, MH provider network credentialing and recredentialing, MH claims and processing and payment, pharmacy services, MH quality and UM services, BH CM, BH prescription Prior Authorizations, MH and

Delegated Entity	Type of Entity and Services
	pharmacy G&A, MH education, reporting, and MH Enrollee and provider call center.
Alpine Technologies	Information Management and Information Systems processes such as maintenance of information integrity, system security, systems availability, and monitoring of critical systems.
InHealth Management LLC.	Hospital UM including evaluation of clinical appropriateness, appeals, and reporting.
IVision	Maintenance of vision claims management system.
First Health Call	Maintenance of provider call line and GHP service lines.
FM Salud	Network administration including adequacy maintenance, credentialing and re-credentialing, provider education, enrollment, claims processing, G&A, and human resources.
Net Claims	Maintenance of dental claims management system and claims payment administrative functions.

FMHP has P&Ps in place operationalizing the auditing, oversight, and monitoring of delegated polices. These policies describe audit and corrective action procedures, protection of Protected Health Information (PHI) and requirements pertaining to sub delegation. FMHP's Compliance Audit and Monitoring Department is responsible for the evaluation of any subcontractor.

Accreditation

Accreditation is not a contract requirement, however FMHP and several of its delegates have accreditation. FMHP currently has Utilization review accreditation commission (URAC) Health Plan Accreditation. APS also holds URAC accreditation as a Health UM organization and a Credentials Verification Organization (CVO). FM Salud holds CVO accreditation, Net Claims solution holds Electronic Healthcare Network Accreditation Commission, Eligibility and Benefits CORE Certification Seal, Claims Status CORE, and Certification Clearinghouse Seal. First Health Call also has URAC accreditation as a Health Call Center.

Employee Training

All FMHP employees are enrolled in a "Welcome On-Board Program" to ensure they complete all regulatory trainings, understand ASES contractual requirements and FMHP P&P's. Employees are given an account in an E-learning platform where new-hire and annual regulatory trainings include compliance, code of conduct, FWA, cultural competency,

HIPAA, QAPI, Medicaid overview, grievances, and advance directives. Delegated entities and subcontractor staff are also required to complete the majority of these trainings. All employees are subject to a proficiency test after the trainings with an 85% passing rate. Employees also participate in trainings specific to their area of hire.

Enrollee Rights and Protections

A review of Enrollee rights and protections covered the following areas:

- Disenrollment requirements and limitations.
- Enrollee rights requirements, including Enrollee rights and responsibilities, advance directives, the right to receive information, and moral and religious objections.
- Information requirements for Enrollees.

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MCO complies with the State enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MCO has written policies related to Enrollee rights and ensure the MCO complies and holds staff and affiliated providers accountable to comply with Enrollee rights and applicable State and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 438.10.

The intent of these regulations is to ensure the MCO provides appropriate information to Enrollees and potential Enrollees in a language and format that is easily understood. The MAO must inform Enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific Enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MCO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (j).

The intent of these regulations is to ensure the MCO maintains P&Ps related to advance directives, including their rights under State law, and must contain clear and concise language on the limitation if the MCO cannot implement an advance directive as a matter of conscience. The MCO is responsible for providing Enrollees with periodic written information regarding advance directives and their rights under the State laws. The MCO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MCO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MCO is responsible for ensuring Enrollees have the right to participate in decisions regarding their care, to be free from any from or restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MCO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements for Enrollee rights and protections, Mercer conducted a thorough review of FMHP's Enrollee facing materials, employee training materials pertaining to Enrollee rights, associated P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through an on-site meeting held on November 6, 2023. The on-site meetings involved participation from MCO key leadership including, but not limited to:

- Enrollee Services Director
- SVP of Clinical Affairs
- Enrollment Director
- Corporate Compliance Director

Overall Assessment

Disenrollment Requirements and Limitations

FMHP has a strong process in place to comply with CFR and contractual requirements pertaining to Enrollee disenrollments. P&Ps indicate that disenrollment occurs only when the Medicaid Program determines that an Enrollee is no longer eligible for the health plan, or when disenrollment is requested by the Contractor or Enrollee and approved by ASES. FMHP also follows disenrollment requirements for the Virtual Region Population and has policies in place stating that this population may not be disenrolled from their auto-enrolled GHP plan. FMHP notifies Enrollees annually of their disenrollment rights and the plan's P&Ps show that Enrollees are notified of the availability of the grievance system and ASES' administrative law hearing (ALH) process when the request for disenrollment is initiated by the MCO.

Enrollees may request disenrollment from the MCO without cause once during the applicable Open Enrollment Period. Enrollees are also notified of grievance and administrative hearing rights and procedures, as indicated in FMHP's P&Ps, and as notified through the Enrollee handbook.

At the time of the review, FMHP's disenrollment P&P did not address the requirement to adjust disenrollment effective dates for Enrollees who are either hospitalized, pregnant, in the appeal process and/or within a month when a terminal diagnosis was made. The plan subsequently submitted an updated policy, dated November 7, 2023, which includes this contractual requirement.

Enrollee Rights Requirements

Regarding Enrollee rights, FMHP ensures all federal and Puerto Rico laws and regulations are adhered to and operationalizes these Enrollee rights in P&Ps and the Enrollee handbook. This includes Enrollee rights to request and receive their health information. FMHP also has a strong process in place to ensure all Enrollees are notified of their rights pertaining to advance directives and employees are trained on these rights upon hire and annually thereafter.

At the time of the review, FMHP's advance directive P&P did not address the requirement to reflect changes in laws no later than 90 calendar days after the effective change. Following the review, FMHP submitted an updated P&P, dated November 7, 2023, which includes this contractual requirement.

FMHP does not currently have a process in place to guide providers and Enrollees when a provider issues a moral or religious objection to cover, reimburse, refer, or issue prior authorization (PA) any service with the scope of the detailed covered services. FMHP will need to develop clear guidance to providers regarding notification requirements to the plan, ASES and Enrollees when providers issue a moral or religious objection.

Information Requirements for Enrollees

Lastly, FMHP adheres to CFR and contractual requirements pertaining to Enrollee information requirements and utilizes ASES' Universal Beneficiary Guide as a model that includes all contractual requirements for the Enrollee handbook. FMHP's P&Ps meet all requirements pertaining to the development and distribution of written materials in alternative formats and language based upon the needs of the Enrollee. There are clear procedures to develop/create, proof, submit, and obtain ASES written approval, publish and/or mail the Enrollee ID card, Enrollee Handbook, Provider Directory, and form letters within contractual standards and timeframes. FMHP also ensures that written Enrollee informational and instructional materials meet the language and format requirements outlined in contract standards. When written materials are requested in alternative formats, policies dictate that the generation of these materials take into consideration the Enrollee's special needs and Enrollees are informed on how to access those formats.

At the time of the review, FMHP's policies did not indicate that Enrollees must be provided with at least 30 calendar days written notice of any significant change in policies concerning Enrollee rights, their right to change PMG or PCP or any of the other items listed as Enrollee rights in the contract. Following the review, FMHP submitted an updated policy, dated November 10, 2023, which includes this contractual requirement.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that reflect an Enrollee may request disenrollment from the MCO without cause once during the applicable Open Enrollment Period (5.2.5, Amendment A). ASES may require an Enrollee seek redress through the MCO's grievance system before ASES makes a determination on the Enrollee's request for disenrollment (5.3.5.8). (42 C.F.R. § 438.56(d)(5)) The MCO will adjust disenrollment effective dates for Enrollees who are either hospitalized, pregnant, in the appeal process and/or within a month when a terminal diagnosis was made in accordance with 5.3.3.3-5.3.5).	Partially Met.	The plan's disenrollment P&P that was in place during the review period (FMHP_12_01.03, effective date February 1, 2022) does not address the requirement to adjust disenrollment effective dates for Enrollees who are either hospitalized, pregnant, in the appeal process and/or within a month when a terminal diagnosis was made. The plan subsequently submitted an updated policy, dated November 7, 2023 which includes this contractual requirement.	None. The plan has updated the associated disenrollment P&P (dated November 7, 2023) to align with contract standards.
The MCO has P&Ps that comply with: written at a fourth grade reading level in English and Spanish;• provided to Enrollees 18 years of age and older; (7.10.1) advise Enrollees of their rights under the laws of Puerto Rico to accept or refuse medical or surgical treatment and the right to formulate Advance Directives; the implementation of those rights, including a statement of any limitation regarding implementation of Advance Directives as a matter of	Partially Met.	The plan's advance directive P&P that was effective during the review period (FMHP_04.10.16) does not address the requirement to reflect changes in laws no later than 90 calendar days after the effective change. However, the plan submitted an updated policy (dated November 7, 2023) indicating this requirement.	None. The plan submitted an updated policy (dated November 7, 2023) indicating the contractual requirement.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
conscience; and the Enrollee's right to file complaint or grievance concerning noncompliance with Advance Directive requirements directly with ASES or with the Puerto Rico Office of the Patient Advocate. (14.9) The P&Ps reflect a description of Puerto Rico law and requires the MCO to reflect changes in laws as soon as possible and no later than 90 calendar days after the effective change (7.10). (42 C.F.R. § 438.3(j)), 42 CFR 422.128(a), 42 CFR.128(b), 42 CFR 489.102(a), and Law No. 160 of Nov 17, 2001.			
The MCO has P&Ps that describe the use of any moral or religious objections to cover, reimburse, refer, or PA any service with the scope of the detailed covered services. The P&Ps include notification to ASES, Enrollees and potential Enrollees as provided in 7.13.1 of the contract. (42 C.F.R. § 438.102(b) and 42 C.F.R. § 438.10(g)(2)(ii)(A and B)) The MCO has P&Ps that permit the Enrollee to change PCP due to moral or religious conflict. (5.4.1.5.1)	Not Met.	The plan's 2022 Provider Guidelines did not reference moral or religious objections made by a provider or provide guidance to providers on how to notify the plan, ASES and the Enrollee.	Develop clear guidance to providers regarding notification requirements to the plan, ASES and Enrollees when providers issue a moral or religious objection. Guidance may be within Provider Guidelines and/or associated P&Ps.
The MCO has P&Ps that require the MCO to provide Enrollees at least 30 calendar days written notice of any significant change in policies concerning Enrollee	Not Met.	Following the on-site review, the plan submitted an updated policy (FMHP_04_09.01) which includes the requirement to provide Enrollees with least	None. The plan has submitted an updated policy (FMHP_04_09.01) dated November 10, 2023

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
disenrollment rights, right to change PMGs or PCPs, or items listed as Enrollee rights and responsibilities in 6.5 of the contract. (6.1.6) (42 C.F.R. § 438.10(g)(4)).		30 calendar days written notice of any significant change in policies concerning Enrollee rights, their right to change PMG or PCP or any of the other items listed as Enrollee rights in 6.5 of the contract. However, this policy was not in place during the review period.	indicating the contractual requirement.

Provider Network — Access and Availability

A review of the provider network covered the following areas:

- Availability of services
- Furnishing of services and timely access
- Access and cultural considerations
- Assurances of adequate capacity and services
- Provider credentialing
- Sub-contractual relationships and delegation
- Practice guidelines

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MCO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MCO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MCO's member demographics, needs, and geographic location when developing the network.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with State requirements. The MCO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network (OON).

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MCO has written P&Ps for the selection and retention of providers and a documented process for the initial and recredentialing of providers. Regulation 438.214(c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214(d) prohibits the MCO from contracting with providers that are excluded from participation in Medicare and State healthcare programs.

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MCO has P&Ps in place which guarantee the MCO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MCO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The intent of these regulations is to ensure the MCO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MCO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers, and financial considerations. **The following federal regulation is addressed in this section: 438.104.**

The intent of this regulation is to ensure the MCO obtains State approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of FMHP's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through on-site meetings held November 6, 2023. The on-site meetings involved participation from MCO key leadership including, but not limited to:

- Compliance and Quality Director
- Network Contracting and Provider Services Director
- Credentialing Director
- Provider Network Director

- Compliance Specialist

Overall Assessment

FMHP provided comprehensive documentation regarding their Medicaid service network. Mercer found most Vital Contract and CFR requirements were documented in the materials submitted for the desk review. Staff provided consistent responses during the on-site meetings and submitted the requested follow-up documents on time. The follow-up documents submitted provided evidence of contractual provisions in all but one area.

FMHP presented with strong leadership and passion for their Enrollees. They consistently monitor the network to ensure access is available for Enrollees. The documentation includes coverage for women's health coverage, family planning, out-of-network (OON) coverage, and second opinions. As a follow-up document, the Provider Network Development Management Plan described goals of ensuring adequacy of FMHP Provider Network for the GHP (Vital), recruitment and retention of providers to provide Enrollees with adequate access to covered services, addressing the need for recruitment of providers for underserved areas and delivering the best personalized service to the provider network. The provider directory is user friendly and shows provider capacity, cultural competency, handicap accessibility, languages spoken, affiliations, and hours of operation. FMHP has a thorough review and reporting process in place, ensuring that the network has a sufficient array of providers and monitoring provider hours of operation. They have strategies to ensure appointment availability timeframes for non-urgent and urgent conditions, and access to services for Enrollees with special healthcare conditions.

FMHP maintains a large network of providers and subcontractors. The providers are trained on the cultural competency plan and FMHP monitors to ensure services are provided in culturally and linguistically appropriate ways for people of diverse backgrounds. The cultural competency plan is shared with the providers annually and a copy is included with quarterly appointment availability surveys.

FMHP subcontracts with APS to provide BH services. APS participated in the on-site review and shared that there is a targeted need for SUD treatment and described the process to identify areas of opportunity and development. An example provided was a need for youth SUD providers on the northwest region of the island where outpatient services are available, but APS is attempting to work with providers to open Intensive Outpatient services to offer additional levels of care.

FMHP has provider guidelines that are distributed to all network providers, and consider the needs of Enrollees, and are reviewed and updated as needed. The provider guidelines also cover the requirement for Autism screening and services as required in the contract.

Provider termination policies were submitted and cover suspensions and terminations, but need to be updated to reflect that FMHP submits a report to ASES even when no action is taken against providers.

Delegation agreements were submitted, verifying the oversight of delegated entities by the delegation department. The following table outlines the subcontractors support Provider Network functions.

Delegated Entity	Type of Entity and Services
APS Healthcare of Puerto Rico	BH network management activities, including contracting and credentialing.
InHealth Management LLC.	Inpatient services.
IVision	Contracting, credentialing, and re-credentialing of optometry providers.

FMHP maintains a large network of providers, offering access to Enrollees. The table below outlines an overview of the MCO network.

Provider Type	Number of Providers
PCP	2,579
PMG	114
Hospital	77
Urgent care	107
Nursing facility	2
Dental	595
Vision	297
BH	1020
FQHC	14

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCOs have written P&P for provider termination that comply with 10.4 and reporting of provider terminations and suspensions. (18.2.5.4)	Partially Met.	FMHP has clear documentation about provider terminations but is lacking verification of reports being submitted to ASES when no action is taken against providers.	Update provider termination and reporting policies to verify reports are submitted to ASES showing when no action is taken against providers.

Coordination and Continuity of Care

A review of the coordination and continuity of care covered the following areas:

- Identification of populations with SHCN

- Enrollee monitoring for medical conditions suggesting a need for care or disease management
- Protection of Enrollee records from unauthorized disclosure per the HIPAA Privacy and Security standards

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MCO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to enrollees with special healthcare needs, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care. The contractor shall develop and implement an integrated CC program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize QOC and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MCO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of FMHP's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through on-site meetings held November 6, 2023. The on-site meetings involved participation from MCO key leadership including, but not limited to:

- Senior Medicaid Director
- UM Director
- VP, Medical Affairs
- Regulatory Report Supervisor
- Medical Affairs Department staff

Overall Assessment

Mercer found FMHP documentation provided evidence of compliance for most, but not all, of the regulatory or contractual provisions.

FMHP policy illustrated processes for ensuring that transition management supports are in place prior to discharge when a member receives inpatient/hospital care, including details regarding admission notification to PCPs and/or PMGs, and discharge notification requirements. This policy also sets requirements for contact with the member once they have returned to the community. FMHP also has policies to ensure that information is consistently shared with PRMP and other MCOs to avoid duplication of services. The CM Program Description document FMHP provided explicitly states that the CM Program is a set of activities designed to eliminate the duplication of services through close collaboration with the member, their PCP, primary medical group, specialists and sub-specialists, service providers, social workers, and other sub-programs.

FMHP provided several P&Ps that described the efforts FMHP has in place to detect over, under, and/or inappropriate service utilization by members with SHCN. Service utilization is used to determine program eligibility and risk stratification, which in turn determines the frequency and intensity of care coordination supports. An overarching goal of the CM Program is to promote effective utilization and monitor healthcare resources, which is supported by the Data Analytics team process for data mining of encounters and identifying service utilization. Additionally, FMHP provided policies ensuring that treatment plan development includes the member, their PCP, and caregivers, as well as the care manager's role in identifying significant changes upon unexpected events, that may require adjustment to the care plan and interventions. Lastly, FMHP policy also addressed the availability of after hours, weekend, and holiday CM availability, illustrating requirements for supervising nurses on call, availability for case staffing when needed, and scheduling of designated staff for weekend and after-hours coverage.

FMHP staff demonstrated multiple levels of quality assurance practices in place to ensure that the requirements for timely, accurate, and comprehensive reporting to PRMP/ASES for CM and Disease Management programs are met. The care managers capture data from multiple sources, and quality indicators are routinely reviewed. FMHP policy illustrates quarterly quality reviews of treatment records, monthly CM program performance reviews with individual care managers, development of performance improvement and CAPs when needed, monthly UM meetings to review metric results, and quarterly quality committee meetings to review metric results as well as discuss any barriers and identify interventions. The process for FMHP to maintain compliance with all contractual reporting requirements to ASES was also outlined within policy.

FMHP policy illustrated processes and strategies to collaborate with intergovernmental agencies, achieve an 85% enrollment rate for both pregnant and non-pregnant members, community outreach, wellness promotion, engaging providers, and targeting and tailoring programs to the different levels of physical and/or behavioral healthcare needs. Mercer was unable to find policy language demonstrating engagement strategies for members living in remote areas as required by PRMP MCO contract section 12.6.1.1. FMHP staff indicated during the on-site review that they offer telehealth services as an option to members, especially when a member is homebound. FMHP provided policies illustrating provider education regarding the provision of Telehealth/Telemedicine services as well as FMHP's TeleMedik vendor contracted to perform Telemedicine and enhance medical care to the Enrollees. When Enrollees are assessed and active in one of the CM Programs, FMHP staff communicates with the PCP and/or the PMG, by outreach calls, mailing or other preferred notification for the Enrollee participation in the sub-programs and their benefits, including

access to Telemedicine services. However, Mercer was unable to find policy language illustrating the provision of Teledentistry services as required by PRMP MCO contract section 7.1.6.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has P&Ps on: Coordination of care that actively links the Enrollee to providers, medical services, residential, social, and other support services, including coordination of care between MCOs, settings of care and discharge planning for short and long-term hospital and institutional stays, and from community and social support providers. The availability of healthcare services through Telehealth, Telemedicine, and Teledentistry. (42 C.F.R. § 438.208(b)(2)) (7.8.2.3.7) (7.1.6 Amendment M)	Partially Met.	FMHP policy illustrates provider education regarding the provision of Telehealth/Telemedicine services and FMHP's TeleMedik vendor contracted to perform Telemedicine. However, Teledentistry is not found within the policies provided.	Policy development or revision to include the ability to access services through Teledentistry.
The MCO's Wellness Plan includes: A strategy for coordination with government agencies of Puerto Rico integral to disease prevention efforts and education efforts, including the Health Department, the Department of the Family, and the Department of Education. The MCO's Wellness Plan incorporates strategies to reach all Enrollees including those living in remote areas of the Contractor's Service Regions. Measurement strategy for reaching at minimum, 85% of GHP Enrollees. Strategy to ensure eighty 85% of pregnant Enrollees receive services under the Pre-Natal and Maternal Program	Partially Met.	FMHP policy details strategies for intergovernmental collaboration, outreach/engage Enrollees to reach the 85% enrollment target, including pregnant members, community outreach, wellness, and promoting group sections, engaging providers, and targeting and tailoring programs to the different levels of physical and/or behavioral care needs. Mercer was	Policy revision or development to address engagement of members living in remote areas.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
Strategies for encouraging Enrollees to: Seek annual healthy checkup; appropriately use the services of the GHP, including GHP Service line; Seek women's health screenings including mammograms, pap smears, cervical screenings, and test for sexually transmitted infections; Maintain a healthy body weight; seek an annual dental exam; Seek BH screening; Attend to the medical and developmental needs of children and adolescents; Receive education regarding the diagnosis and treatment of high-risk diagnosis including: Depression; Schizophrenia; Bipolar disorders; Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder; Substance abuse and Anxiety disorders. (7.5.8.2) (12.5.8.2) (12.6.1.2.1-9) (12.6.1.3)		unable to locate policy language addressing strategies specific to members in remote areas.	

UM

A review of UM covered the following areas:

- Coverage and authorization of services
- Compensation for UM activities
- Emergency and post-stabilization services
- Timeframes for authorization decisions
- Prescription drug authorization requirements
- Adverse benefit determination

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MCO, with input from providers, has CPG in place that reflect the needs of Enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MCO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the Enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MCO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of FMHP's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through on-site meetings held November 6, 2023. The on-site meetings involved participation from MCO key leadership including, but not limited to:

- UM Manager, FMHP
- UM Director, FMHP
- Regulatory Support Supervisor
- Clinical Pharmacist, FMHP
- Pharmacy Manager, APS
- Senior Medical Director
- UM Director, APS
- VP Medical Affairs
- Director of Clinical Operations

Overall Assessment

The FMHP UM processes include provides pre-service authorization, concurrent and retrospective reviews. The medical and BH services that require PA are clearly defined. UM decision making, timeframes and timeliness for specified services are well defined through

the UM program description and P&P's. The UM program description and Work Plan is updated annually and reflects trends identified throughout the year.

All FMHP UM staff are dedicated to Puerto Rico Medicaid. The Senior Medical Director is responsible for clinical oversight of the UM department. These staff include physical, BH and pharmacy. PH currently has 47 positions and uses Milliman for their clinical guidelines. BH has 28 positions including physician advisors who are psychiatrists. The pharmacy team consists of eight positions within FMHP and 24 positions within APS, the pharmacy delegated entity. PA utilization staff are registered nurses, pharmacy technicians, PharmD, licensed socials workers and psychologists. Only physicians can make an adverse decision to deny or issue an authorization that is less than requested.

MedHOK (MHK) is the electronic pre-authorization software used by FMHP. Reporting and monitoring are completed weekly and monthly using the reports generated by MHK. Daily service level agreements are monitored, and risk and compliance are identified through this software program. Supervisors and managers perform monitoring on the use of the guideline's applicability, medical necessity, and timeliness of decisions. A monthly scorecard is submitted by APS Pharmacy and is reviewed by UM supervisors and the Quality Board. The CMO of FMHP is ultimately responsible for oversight of supervision and monitoring.

FMHP has a UM committee that meets on a quarterly basis to review the utilization activities, including any trends, findings, and recommendations, the over and underutilization metrics, and appeal and grievance data. The forum also provides the opportunity to integrate physical BH strategies. The UM department staff is responsible for identification of QOC issues and these and other data metrics are reported on a quarterly basis to the quality advisory board as a sub-committee. FMHP also has a Clinical Practice Guidelines (CPG) Committee to evaluate, review, monitor, and disseminate the CPGs to all network providers.

FMHP utilizes two delegated entities as part of the UM operations. The Compliance Audit and Monitoring department is responsible for conducting pre-delegation audits prior to entering into a contractual agreement with a subcontractor. Once approved through the Compliance Committee, the Quality Advisory Board and the Delegated Entities sub-committee, the Compliance Audit and Monitoring department are responsible for routine monitoring activities and an annual performance audit.

APS is fully delegated to provide BH UM including prior authorization, clinical concurrent reviews, discharge planning, medical necessity review, physician consultation, managing appeals, and managing the MH clinical programs. FMHP uses an Interdisciplinary Care Team which includes representation from pharmacy, utilization, quality, CM regulatory and medical affairs, and APS to discuss complex cases and coordinate care. APS has a UM committee that meets quarterly.

Inhealth is fully delegated to provide hospital UM including concurrent and retrospective reviews in hospital, and acute and subacute levels of care, appeals and developing hospital UM reports.

Both medical and BH staff utilize Milliman Care Guidelines (MCG), FMHP policies, and ASES contractual regulations to determine clinical necessity. The IRR audit process is conducted annually.

MCO staff provided consistent documentation and responses regarding the timeframe for PA decisions, providing written notice of adverse benefit determinations, ensuring that emergency services do not require a referral or prior authorization, and provided policies to ensure that staff are not incentivized for making UM decisions.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has written UM P&Ps to assist Enrollees and providers to ensure appropriate utilization of resources. The MCO's P&Ps reflect the subcomponents listed under 11.2.1 of the GHP contract. (42 C.F.R. § 438.210(a)(3 and 4) and 42 C.F.R. § 438.210(b))	Partially Met.	FMHP UM program description and P&P does not include language that addresses the requirement that relapse and crisis prevention is emphasized in the UM program. APS stated during on-site review they identified member who might be readmitted and a referral is made to complex case management. No policy was submitted that substantiates for relapse and crisis prevention.	FMHP and its delegates should develop P&P's which adheres to all requirements of the subcomponents listed under 11.2.1 of the GHP contract. (42 CFR 438.210 (a) (3 and 4) and CFR 438.210 (b) which are related to relapse and crisis prevention.
The MCO has written P&Ps that reflect that: (i) emergency services do not require a referral or prior authorization, no matter whether the Provider is within the preferred provider network (PPN) (11.4.6); (ii) the MCO covers post-stabilization services consistent with the requirements in 7.5.9.4 of the contract; and (iii) the Enrollee treated for an emergency medical condition or psychiatric emergency shall not be held liable for any subsequent screening or treatment necessary to stabilize the	Partially Met.	FMHP reports that they and their delegates cover post-stabilization services and the member is not liable, however formal documentation was not provided.	Revise policy to ensure that language related to post-stabilization services for FMHP and its delegates is clearly included.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
Enrollee. (7.5.9.4.2) (42 C.F.R. § 438.114)			

G&A

A review of G&A covered the following areas:

- General grievance system requirements, including:
  - Information about the grievance systems shared with providers and subcontractors
  - Grievance system P&Ps
  - Authority to file
  - Handling of G&A
  - Recordkeeping requirements
- Grievance system management, including the grievance process and resolution and notification
- Appeals process management, including the appeals process and resolution and notification

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MCO has in effect a G&A system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MCO must inform members of how to access the grievance system, the availability of the MCO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MCO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MCO provides NOABD letters that are compliant with language, content, and format as required by Enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MCO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MCO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MCO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MCO must keep a log of all G&As filed. The MCO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of FMHP's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on

information submitted by the MCO through the RFI and through on-site meetings held November 6, 2023. The on-site meetings involved participation from MCO key leadership including, but not limited to:

- Director, G&A
- Director, Operations

Overall Assessment

The grievance system follows standard processes. Complaints, grievances, and appeals can be received from members, member representatives, or providers verbally through Customer Services, in person at a service center, or be written (i.e., filling out a form on the FMHP website and submitting it). If a grievance is received verbally, a technician registers the request in the MHK system, generates an acknowledgement letter, and a Coordinator is assigned to manage the request. This cloud-based system is a repository for all Member complaints, grievances, and appeals received and is used to track compliance with documentation and timeliness requirements. There are 20 full-time employees (FTEs) dedicated to the Puerto Rico Medicaid line of business for grievance system management. FMHP delegates BH G&A to APS Healthcare who has access to FMHP's MHK system for seamless sharing of information.

The Grievance Coordinator facilitates the grievance investigation, including coordinating investigations with other impacted business units. For example, the Provider Network Management (PNM) team will be sent quality of service grievances; QOC issues are investigated by a clinical provider. Any information that is sent to or received from other units of FMHP during the investigation is documented in MHK. At the completion of the investigation, the Grievance Coordinator sends a resolution letter to the member within two business days of the resolution.

Member complaints are received, documented, and resolved by Customer Service within 72 hours of the initial call. If a complaint is not able to be resolved within 72 hours, it is referred to the G&A department for investigation and resolution. Complaints data is aggregated with grievance data and shared with appropriate operational areas to identify continuous improvement opportunities.

Similar to grievances, standard appeals are accepted both verbally (through Customer Services) or in writing (appeals form can be found on the FMHP website) and sent to FMHP via US mail, fax, or email. Appeals filed by providers are required to have written member consent. The appeal start date is the date the appeal is received.

Appeals staff are responsible for sending out member correspondence including the initial acknowledgement letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuity of care is requested in the appeal, the technician checks to ensure the proper steps have occurred and timelines are met. The member or member representative has the opportunity to present the case and answer any questions. The case is deliberated, and a decision is issued and communicated to the member verbally and in writing.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO's Grievance System P&Ps include: Process and timelines for filing a Complaint, Grievance, or Appeal, or seeking an ALH; Process for receiving, recording, tracking, reviewing, reporting, and resolving Complaints, Grievances, and Appeals filed verbally, in writing, or in-person; Process for requesting an expedited review of an Appeal; Process for notifying Enrollees of their right to file a Complaint, Grievance, or Appeal with the Patient Advocate Office and how to contact the Patient Advocate Office; Procedures for the exchange of information with providers, ASES, and Enrollees regarding Complaints, Grievances, and Appeals; Process and timeframes for notifying Enrollees in writing regarding receipt, resolution, action, delay of review, and denial of request for expedited review of Complaints, Grievances, and Appeals. Process for providing Enrollee available assistance in filing a Grievance or Appeal with the Contractor Process for written Notices of Adverse Benefit Determination to Enrollees must meet the language and format requirements in section	Partially Met.	The MCO has implemented a system (MHK) change to allow for manual entry of the timeline for complaints/grievance resolution according to the time/date the request was made. It should be noted that if only 11 complaints were received in a five-year period, the MCO is likely not capturing all member complaints for inclusion in tracking and trending reports.	Conduct an audit of member service calls received to ensure that all complaints are captured and reported appropriately and provide training to member-facing staff on identifying complaints and grievances as needed based on audit findings.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
6.2 and 6.3 and be set in accordance with the timeframes described in GHP section 14.4.4 and details in 14.5.15. (42 CFR § 438.402) (6.4.5.27.3) (14.1.5) (14.4.2) (Platino 11.1.5)			
The MCO's P&Ps, Enrollee Handbook, and Provider Manual clearly state that an Enrollee may file an appeal verbally or in writing within 60 Calendar Days after receiving an Adverse Benefit Determination and will acknowledge receipt of the appeal. (42 CFR §438.402 (2)(ii)) (GHP 14.5.2, 14.5.4)	Partially Met.	Notice of adverse benefit determinations (NOABD) letter template revisions will be made on November 28, 2023 to align with content requirements. Draft letter template appears to contain appropriate language.	Review and revise member and provider materials to align with MCO policies, contract, and federal requirements. Provide revised letter template.

QAPI Program

A review of the QAPI program includes the following:

- The presence of an ongoing comprehensive QAPI program
- Monitoring and assessment of the QAPI
- Analysis and reporting of the QAPI
- PM
- PIPs

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MAO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to , utilization, claims, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330.

The intent of this regulation is to ensure the MCO has an ongoing quality assessment and PIP for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with SHCN.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of FMHP's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through on-site meetings held November 6, 2023. The on-site meetings involved participation from MCO key leadership including, but not limited to:

- VP
- Compliance Auditor
- Quality Supervisor
- Quality Manager, APS
- SVP, Clinical Affairs, APS

Overall Assessment

Mercer found all required documentation provided evidence of compliance with regulatory or contractual provisions. During the on-site review, Mercer also observed FMHP staff provided responses that were consistent with each other and with the submitted documentation.

The Mercer assessment further found that FMHP has comprehensive P&Ps and work plans to support its QAPI activities and oversight responsibilities. FMHP illustrates a thorough, comprehensive process to describe the methodology used to monitor, analyze, evaluate, and improve the delivery, quality, and appropriateness of healthcare offered to their beneficiaries, including those with special needs. FMHP illustrated a goal within the QAPI program to develop P&Ps that ensure continuous QI and UM, including mechanisms to detect inappropriate use of services (underutilization and overutilization). Annually, FMHP collaborates with its Quality Advisory Board/Quality Committee to develop the Annual QAPI Program Description, QAPI Work Plan, and the QAPI Evaluation to assess the impact and effectiveness of the QAPI Program and the previous year's activities.

Additionally, FMHP has invested significant resources to strengthen the infrastructure of its information systems and applications for the development of reports and other technology, that facilitate optimal, accurate and complete collection of information. In an effort to close gaps in care, FMHP uses all health insurance claims, surveys, and clinical documentation from hospitals, pharmacies, laboratories, and doctors' offices to confirm patient preventive services were completed and identify which preventive services are still needed. FMHP has also enhanced its reporting capability by developing more specific reports and increase reporting frequency to better monitor its compliance with requirements for HEDIS measures and CMS' Adult and Child Core Measure Set metrics.

Lastly, FMHP, through its QAPI Program, has established monitoring tools that are designed to track the performance of quality measures for PIPs and operational functions and standards. FMHP has a detailed work plan that describes the action steps associated with conducting the PIPs, outlining measurable objectives, actions steps, cadence for meeting and reporting, and responsible parties for various quality issues related to these performance activities.

Findings

FMHP met all requirements for these metrics through RFI documents, on-site discussions, and post on-site submissions.

MMM GHP

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through on-site meetings held November 7, 2023. The on-site meetings involved participation from MCO key leadership including, but not limited to:

- Medicaid Chief Operating Officer (COO)
- Provider Education, AVP
- Contracting, AVP
- Director of Operations, MSO
- MH Regulatory Director
- Provider Network, AVP
- Pharmacy Services, VP
- Pharmacy Services, AVP
- CM Director
- Pre-Authorization Senior Director

- MH Ops, AVP
- CMO
- Associate Chief Medical Officer
- Chief Clinical Ops. Officer
- GHP Clinical Operations, AVP
- Corporate Medical Director, MH
- Director of Outpatient UM
- Director of Grievances and Appeals
- Quality Management (QM), VP
- QM, Associate VP
- QM, Staff VP
- QM Director
- Compliance Specialists

Strengths

The MMM on-line Provider Directory is user friendly and includes all fields that are contractually required, as well as enhancements such as the MMM on-line directory identifies if the provider performs home visits and provides a link that Enrollees may use to request further information on the provider's credentials.

MMM had a strong strategic reporting team specializing in efficient data collection capabilities, report analysis, timely problem solving and knowledge of any new industry standards.

MMM developed an island-wide initiative to visit providers and medical groups and ensure the providers comply with the encounter metrics.

Opportunities for Improvement

There is an opportunity for the MCO to enhance continuous improvement efforts by (informally) investigating all grievances received.

MMM has the opportunity to enhance the PIP Aim Statements by clearly stating the improvement strategy, target population, measurable impact, and time period within each PIP structures as well as demonstrate continuous QI techniques within the PIP evaluation process.

There is an opportunity for MMM to review the initial intake claims processing and application of the SNIP level standards.

Recommendations

It is recommended that MMM provide an update to the Provider Termination P&P to address the reporting requirements to ASES within the required timeframes. Develop a process to track and report within the contractual timeframes.

It is recommended that MMM develop PIP Aim Statements that are clear, concise, measurable, and answerable, as well as adopt and implement continuous QI methodologies with the PIP process.

MMM staff's knowledge of SNIP levels, implementation and importance of SNIP levels could be enhanced to ensure alignment with the national standards and to confirm the EDI files are created properly and according to the HIPAA rules. It is recommended MMM complete a gap analysis to determine what level (if any) of SNIP edits are applied and to determine if any enhancements are necessary.

Administration and Organization

Overview

Organizational Structure

MMM administers its GHP under MMM, a subsidiary of MMM Holdings, LLC. MMM Healthcare, LLC operates under a corporate board of directors which oversees an executive leadership team. This executive leadership team is the same for all lines of business under MMM Holdings, LLC and includes a Compliance Officer, the COO, the CMO, the VP of Medicaid Operations, the VP of QM, and Five Stars Ops, and legal counsel. Within MMM GHP, the VP of Medicaid Operations provides oversight of member services (including call centers and regional offices) and enrollment; the CMO oversees G&A. A related entity under MMM Holdings, LLC, the MSO of Puerto Rico, LLC (MSO), oversees clinical services, CM, UM, social work, and network management.

Delegated entities

MMM delegates responsibilities to 12 entities as described in the table below.

Delegated Entity	Type of Entity and Services
APS Healthcare of Puerto Rico *(Contract ended November 2018)*	MH benefits, MH provider network credentialing and re-credentialing, MH claims and processing and payment, pharmacy services, MH quality and UM services, BH CM, MH and pharmacy G&A, MH education, reporting, MH Enrollee, and provider call center
ATENTO	Beneficiary call center
InHealth Management	Hospital UM
Insight	Provider call center for after-hours calls

Delegated Entity	Type of Entity and Services
INSPIRA	MH contracting and credentialing of MH providers
Ivision	Vision claims management
MSO of Puerto Rico	UM, clinical services (PH and MH), claims, pharmacy, HRA, contracting, credentialing and network management, audits and monitors contracted delegated entities
Net Claims Solution	Dental Services — Claims processing, direct members reimbursements, dental preservice platform
PMGs: PHM	Educational activities related to the Wellness program
PMGs: Redes del Sureste	Educational activities related to the Wellness program
PMGs: Alianza	Educational activities related to the Wellness program
Telemedik	PMG call center Medicaid

MMM has P&Ps in place which operationalize the monitoring, oversight, and auditing of delegated entities and delegates these responsibilities to MSO. MMM provided evidence of similar P&Ps utilized by MSO for sub-delegates. MSO reports to MMM's dedicated unit, the Delegation Oversight Department, which is ultimately responsible for contract and regulatory oversight of delegated entities.

Accreditation

Although not a contractual requirement, MMM is pursuing a NCQA health equity accreditation with a proposed effective date of January 2024.

Employee Training

MMM has an established training program for new hires, subcontractors and providers offered virtually or via an online educational platform. MMM requires new hire training within 90 days of hiring and requires either an exam or an attestation of completion. All subcontractors must present attestations as proof of completion. Staff and all delegates and sub-contractors are trained in advance directives, cultural competency, FWA, HIPAA, BH, Enrollee rights, G&A, Medicaid and covered Medicaid services, compliance, including Code of Conduct, and the financial exploitation of aging adults and adults with disabilities.

Enrollee Rights and Protections

A review of Enrollee rights and protections covered the following areas:

- Disenrollment requirements and limitations
- Enrollee rights requirements, including Enrollee rights and responsibilities, advance directives, the right to receive information, and moral and religious objections
- Information requirements for Enrollees

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MCO complies with the state enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MCO has written P&Ps related to Enrollee rights and ensure the MCO complies and holds staff and affiliated providers accountable to comply with Enrollee rights and applicable state and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 438.10.

The intent of these regulations is to ensure the MCO provides appropriate information to Enrollees and potential Enrollees in a language and format that is easily understood. The MCO must inform Enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific Enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MCO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (j).

The intent of these regulations is to ensure the MCO maintains P&Ps related to advance directives, including their rights under state law, and must contain clear and concise language on the limitation if the MCO cannot implement an advance directive as a matter of conscience. The MCO is responsible for providing Enrollees with periodic written information regarding advance directives and their rights under the state laws. The MCO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MCO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MCO is responsible for ensuring Enrollees have the right to participate in decisions regarding their care, to be free from any form of restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MCO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements for Enrollee rights and protections, Mercer conducted a thorough review of MMM's Enrollee-facing materials, employee training materials pertaining to Enrollee rights, associated P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through an on-site meeting held on November 7, 2023. The on-site meetings involved participation from MCO key leadership including, but not limited to:

- Compliance Specialist
- Enrollment Manager
- Member Services Representative

Overall Assessment

Disenrollment Requirements and Limitations

MMM has a strong process in place to comply with CFR and contractual requirement pertaining to Enrollee disenrollments. P&Ps indicate that disenrollment occurs only when the Medicaid Program determines that an Enrollee is no longer eligible for the health plan, or when disenrollment is requested by MMM or Enrollee and approved by ASES. MMM notifies Enrollees annually of their disenrollment rights and the plan's P&Ps show that Enrollees are notified of the availability of the grievance system and ASES' ALH process when the request for disenrollment is initiated by the MCO.

Enrollees may request disenrollment from the MCO without cause once during the applicable Open Enrollment Period. Enrollees are also notified of grievance and administrative hearing rights and procedures, as indicated in MMM's P&Ps, and as notified through the Enrollee handbook.

MMM's current disenrollment P&Ps do not include requirements that the health plan will adjust disenrollment effective dates for Enrollees who are either hospitalized, pregnant, in the appeal process and/or within a month when a terminal diagnosis. MMM will need to amend the existing disenrollment P&Ps to reflect these requirements.

Enrollee Rights Requirements

Regarding Enrollee rights, MMM ensures all federal and Puerto Rico laws and regulations are adhered to and operationalizes these Enrollee rights in P&Ps and the Enrollee handbook. This includes Enrollee rights to request and receive their health information. MMM also has a strong process in place to ensure all Enrollees are notified of their rights pertaining to advance directives and employees are trained on these, and all other Enrollee rights.

MMM does not currently have a process in place to guide providers and Enrollees when a provider issues a moral or religious objection to cover, reimburse, refer, or issue PA any service with the scope of the detailed covered services. MMM will need to develop clear guidance to providers regarding notification requirements to the plan, ASES and Enrollees when providers issue a moral or religious objection.

Information Requirements for Enrollees

MMM adheres to CFR and contractual requirements pertaining to Enrollee information requirements and utilizes ASES' Universal Beneficiary Guide as a model that includes all contractual requirements for the Enrollee handbook. MMM's P&Ps meet all requirements pertaining to the development and distribution of written materials in alternative formats and language based upon the needs of the Enrollee. There are clear procedures to develop/create, proof, submit and obtain ASES written approval, publish and/or mail the Enrollee ID card, Enrollee Handbook, Provider Directory, and form letters within contractual standards and timeframes. MMM also ensures that written Enrollee informational and instructional materials meet the language and format requirements outlined in contract standards. When written materials are requested in alternative formats, P&Ps dictate that the generation of these materials take into consideration the Enrollee's special needs and Enrollees are informed on how to access those formats.

MMM does not have P&P in place to ensure Enrollees are provided with at least 30 calendar days written notice of any significant change in P&Ps concerning Enrollee disenrollment rights, right to change PMGs or PCPs, or items listed as Enrollee rights and responsibilities in the contract. MMM will need to develop a P&P indicating these contractual requirements.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that reflect an Enrollee may request disenrollment from the MCO without cause once during the applicable Open Enrollment Period (5.2.5, Amendment A). ASES may require an Enrollee seek redress through the MCO's grievance system before ASES makes a determination on the Enrollee's request for disenrollment (5.3.5.8). (42 C.F.R. § 438.56(d)(5)) The MCO will adjust disenrollment effective dates for Enrollees who are either hospitalized, pregnant, in the appeal process and/or within a month when a terminal diagnosis was made in	Not Met	The plan does not have a P&P indicating it adjusts effective disenrollment dates for Enrollees who are either hospitalized, pregnant, in the appeal process and/or within a month when a terminal diagnosis was made.	Amend the existing disenrollment P&Ps to indicate the plan adjusts effective disenrollment dates for Enrollees who are either hospitalized, pregnant, in the appeal process and/or within a month when a terminal diagnosis was made.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
accordance with 5.3.3.3-5.3.5).			
The MCO has P&Ps that describe the use of any moral or religious objections to cover, reimburse, refer, or PA any service with the scope of the detailed covered services. The P&Ps include notification to ASES, Enrollees and potential Enrollees as provided in 7.13.1 of the contract. (42 C.F.R. § 438.102(b) and 42 C.F.R. § 438.10(g)(2)(ii)(A and B)) The MCO has P&Ps that permit the Enrollee to change PCP due to moral or religious conflict. (5.4.1.5.1)	Not Met	The plan did not provide any P&Ps or other evidence showing how the plan guides providers when they have a moral or religious objection or how providers should notify the plan, ASES, and Enrollees of these objections.	Develop clear guidance to providers regarding notification requirements to the plan, ASES, and Enrollees when providers issue a moral or religious objection. Guidance may be within Provider Guidelines and/or associated P&Ps.
The MCO has P&Ps that require the MCO to provide Enrollees at least 30 calendar days written notice of any significant change in P&Ps concerning Enrollee disenrollment rights, right to change PMGs or PCPs, or items listed as Enrollee rights and responsibilities in 6.5 of the contract. (6.1.6) (42 C.F.R. § 438.10(g)(4)).	Not Met	The plan did not submit a P&P or other evidence showing how or when the plan notifies Enrollees of any significant change in P&Ps concerning disenrollment rights, right to change PMGs or PCPs, or items listed as Enrollee rights and responsibilities (in accordance with Section 6.5 of the contract).	Develop a P&P indicating compliance with Section 6.5 of the contract which requires plans to provide Enrollees with at least 30 calendar days written notice of any significant change in P&Ps concerning disenrollment rights, right to change PMGs or PCPs, or items listed as Enrollee rights and responsibilities.

Provider Network — Access and Availability

A review of the provider network covered the following areas:

- Availability of services
- Furnishing of services and timely access

- Access and cultural considerations
- Assurances of adequate capacity and services
- Provider credentialing
- Sub-contractual relationships and delegation
- Practice guidelines

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MCO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MCO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MCO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MCO has written P&Ps for the selection and retention of providers and a documented process for the initial and recredentialing of providers. Regulation 438.214(c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214(d) prohibits the MCO from contracting with providers that are excluded from participation in Medicare and state health care programs.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with State requirements. The MCO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network (OON).

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MCO has P&Ps in place which guarantee the MCO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MCO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The intent of these regulations is to ensure the MCO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MCO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers, and financial considerations.

The following federal regulation is addressed in this section: 438.104.

The intent of this regulation is to ensure the MCO obtains State approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through on-site and/or virtual meetings held November 7, 2023. The on-site meetings involved participation from MCO key leadership including, but not limited to:

- Medicaid COO
- Provider Education, AVP
- Contracting, AVP
- Provider Network Operations
- Director of Operations, MSO
- MH Regulatory Director
- Provider Network, AVP
- Compliance Specialist

Overall Assessment

MMM's comprehensive documentation provided evidence of processes in place to meet Medicaid service network requirements for Enrollees as required through the Plan Vital Contract and CFR requirements. MMM provided the organizational structure that is in place for network management, with the Provider Network Operations Director having the oversight of PNM. MMM delegates contracting and credentialing to MSO and the Network Excellence and Experience Unit provides support to any internal area that needs a direct intervention with the provider, supporting not only the provider, but also the Enrollee. MMM's 2023 Annual Provider Network Development and Management Plan and Evaluation outlines the process for addressing when significant operational changes affecting service capacity or adequacy are reported for compliance with ASES requirements. MMM utilizes the Adequacy Report to identify and address service gaps. The plan includes conducting quarterly surveys, the findings of which are validated by the Network Management and Contracting Departments through direct interactions with providers. These findings and subsequent actions are then reported to ASES in Report 17, Appointment of Availability, ensuring ongoing monitoring and adherence to regulatory standards.

The MMM on-line Provider Directory is user friendly and includes all fields that are contractually required, these requirements include: names of physicians, including specialists, hospitals, pharmacies, and BH providers, along with their provider group affiliations, locations, office hours, telephone numbers, websites, cultural and linguistic capabilities, completion of Cultural Competency training, and accommodations for people with physical disabilities and network providers that are not accepting new patients. In addition to the contractual requirements, the MMM on-line directory identifies if the provider performs home visits and provides a link that Enrollees may use to request further information on the provider's credentials. Search filters are available based on language spoken, gender, ethnicity and other (accepting new patients and handicap accessible). Enrollees are able to request a hard copy of the provider directory by calling the member services department. In addition, the Enrollee has the ability to submit information that they found to be incorrect through the on-line directory. Last, the on-line directory provides the ability for the user to increase the overall font size two times larger. The paper directory is updated monthly while the online version is updated on a daily basis.

Provider Guidelines for MMM are produced by MSO and are included within the Provider Manual. The manual is a comprehensive document that educates the provider network on requirements as well as the process of MMM to support the network. The Provider Manual meets the contractually required topics for inclusion and is distributed to the Provider within 15 days of contracting and to Enrollees/Potential Enrollees upon request. To meet the CFR § 438.206 Availability of services requirement, the Provider Manual provides guidance on Plan Vital coverage for family planning services and the right for Enrollees to go to a women's health specialist in their plan (such as a gynecologist) without a referral. The P&P Enrollees Access to Specialists and other Providers outlines the process for OON providers. MMM provided the P&P for Second Opinion program, which promotes access for Enrollees to obtain a second medical opinion without additional cost, both within and outside their network. Enrollees may request a second opinion from a participating specialist for serious conditions such as cancer or neurological disorders. PA is not required for in-network second opinions.

MMM submitted a comprehensive Cultural Competency Plan. It is a holistic approach demonstrating MMM's commitment to equitable and sensitive healthcare provision. The Cultural Competency Plan encompasses a range of strategies tailored to their diverse beneficiary base. It includes analyzing demographic data to understand better and serve different population groups, providing linguistic and interpreting services for non-Spanish speakers, and sensitive indicators to respect various religious beliefs. The plan also emphasizes anti-discrimination P&Ps for the LGBTQ+ population, addresses preferential turns to meet the needs of beneficiaries from island municipalities of Vieques and Culebra, and caters to the unique requirements of the elderly and disabled.

The provider contracts include fields required by the Plan Vital contract and the Provider Termination P&P document outlines the termination processes for the GHP. It specifically focuses on the methods and management of these terminations but does not address the reporting requirements to ASES or any other entities.

MMM delegates contracting and credentialing to MSO and the documents submitted provides the process for contracting and credentialing that meets Plan Vital requirements including procedures for confirming the enrollment of providers as Medicaid Providers. The P&P emphasizes that MSO and its contracted providers are prohibited from contracting with or employing individuals excluded from federal and state programs. The process for providers to report on terminations is clear through the submitted documents, however the documents do not include the process to inform ASES on provider terminations. The Plan Vital Contract requires that the MCO notify ASES at least 45 calendar days prior to the effective date of the suspension, termination, or withdrawal of a Provider from participation in the MCO’s network. If the termination was “for cause,” the MCO is required to provide ASES the reasons for termination immediately and within15 calendar days after receipt or issuance of a notice of termination to a Provider, the MCO is required to provide written notice of the termination to Enrollees who received his or her Primary Care from, or was seen on a regular basis by, the terminated Provider, and assist the Enrollee as needed in finding a new Provider.

The following table outlines the subcontractor for MMM supports Provider Network functions.

Delegated Entity	Type of Entity and Services
MSO of Puerto Rico	Provider contracting and credentialing, network adequacy. MSO may also subcontract to other entities.

The following table outlines the subcontractors for MSO support Provider Network functions.

Delegated Entity	Type of Entity and Services
Inspira Behavioral Care Corporation	Network functions, including contracting and credentialing of MH providers.
Ivision Contracting	Network functions, including contracting and credentialing of vision care providers.

The P&P on Reporting Requirements mandates compliance with reporting and data validation as per its contractual obligations with CMS, PRMP, and ASES. Failure to comply may result in warnings, corrective action requests, and potential sanctions like monetary fines or contract termination. The Chief Compliance Officer oversees adherence to various documents and memoranda from CMS, PRMP, and ASES and the Compliance Department is responsible for submissions to ASES within deadlines. The procedure for reporting requirements involves a structured process that includes reminders from the Compliance Officer for data submission, followed by data collection, validation, and review by the Operational Owner/subject matter expert (SME). The Compliance Department then submits these reports and archives them, with provisions for data correction and resubmission, including adherence to CAPs, when necessary, within specified timeframes.

MMM is accountable for monitoring and oversight of the provider network is performed through various methods. The P&Ps as well as reports submitted are detailed and provide a thorough review process for the network. The Appointment Availability report includes review of the provider address, phone number, language, acceptance of new patients, the date of cultural training. MMM and MSO subcontractor oversight P&Ps provide clear processes to monitor network tasks that are delegated.

To address provider recruitment and retention, MMM offers reimbursement to providers that offer extended hours. MMM offers P4P to urgent care providers based on contractual performance measures. The provider manual requires that Medically Necessary Services shall be available 24 hours per day, seven days per week, to the extent feasible and describes the process to monitor provider hours. The provider contracts include requirements to provide Members an adequate amount of space for services provided and disabilities treated, including waiting and reception areas, staff space, examining rooms, treatment areas, and storage. The documents submitted did not include the process to ensure that Network Providers offer hours of operation that are no less than the hours offered to commercial Enrollees or are comparable to Medicaid fee-for-service if the Provider serves only Medicaid Enrollees.

The 2022 Provider Guidelines from MMM, outline their method for providing necessary educational materials to providers, as required contractually. The Medicaid Compliance Department carefully selects essential regulatory topics pertinent to providers and their patients each year. These materials, sourced from state and federal regulators, aim to maintain standardization, and adhere to the CMS educational requirements. The topics covered include MMM's Code of Conduct, Compliance, and Integrity Program (which focuses on FWA), Cultural Competency Plan, G&A System, Advance Directives, and HIPAA Law (covering Privacy and Security), along with other essential regulatory topics.

Number of MMM Contracted Providers in 2022:

Provider Type	2022 Number of Providers
PCP	2,072
PMG	100
Hospital	45

Provider Type	2022 Number of Providers
Urgent care	84
Nursing facility	3
Dental	927
Vision	839
BH	785
FQHC	21

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCOs have written P&P for provider termination that comply with 10.4 and reporting of provider terminations and suspensions. (18.2.5.4)	Partially Met	MMM's submissions did not include a documented process or workflow for communicating with ASES regarding provider termination, as mandated by the contractual requirement. MMM is to inform ASES within two business days prior to taking action.	Provide an update to the Provider Termination P&P to address the reporting requirements to ASES within the required timeframes. Develop a process to track and report within the contractual timeframes.

Coordination and Continuity of Care

A review of the coordination and continuity of care covered the following areas:

- Identification of populations with SHCN
- Enrollee monitoring for medical conditions suggesting a need for care or disease management
- Protection of Enrollee records from unauthorized disclosure per the HIPAA Privacy and Security standards

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MCO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to Enrollees with special health care needs, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated Continuation of Care program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize QOC and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MAO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through on-site meetings held November 7, 2023. The on-site meetings involved participation from MCO key leadership including, but not limited to:

- AVP of Pharmacy Services
- CM Director
- CM Manager
- Pre-Authorization Senior Director
- AVP of MH Ops
- MH Corp. Medical Director
- Associate Chief Medical Officer
- Chief Clinical Ops. Officer
- AVP of GHP Clinical Operations
- Compliance Specialists

Overall Assessment

Mercer found MMM documentation provided evidence of compliance for some, but not all, of the regulatory or contractual provisions.

MMM demonstrated P&Ps and strategies to support reaching and enrolling 85% of pregnant members in the maternal wellness program with its community-based CM team and dedicated prenatal CM team comprised of specialists from the field, often with additional certifications, like Lamaze or breast-feeding specialist. The MMM P&P also included details regarding the implementation of an obstetrics registry and prenatal program to address specific population needs, as well as facilitating educational workshops on prenatal topics. The P&Ps also require monitoring to ensure MMM meets the 85% enrollment target, and process to submit quarterly reports to track program utilization.

MMM staff also provided P&Ps that support the routine monitoring of CM services, as well as routine and timely reporting to PRMP/ASES. MMM completes quarterly auditing on CM indicators including face to face interventions, care level, call frequency, and participation rate. MMM CM staff coordinate with staff from the Quality and Compliance department to complete all PRMP/ASES reporting requirements.

MMM provided its P&P and Beneficiary Manual defining eligibility requirements for the HCHN program and Special Coverage, as well as how the CM programs are provided and processes for the CM team to create a plan and review the plan at least annually or as needed. Mercer was unable to find language in its Beneficiary Manual and notices requiring the provision of instructions to Enrollees and Potential Enrollees on how to access continued services pursuant to MMM's transition of care process per section 6.1.8 of the PRMP MCO contract.

MMM also provided P&Ps that addressed the use of Telehealth and Telemedicine in MH and substance use programs. Language indicated that members who are bedridden, are home bound, have mobility problems, have emotional conditions, reside in group homes, or are hospitalized in Unidad Dorada shall be the priority populations for telepsychiatry. Mercer was unable to find details regarding the use of Telehealth and Telemedicine for PH supports, or language addressing the use of Teledentistry.

Section 7.7.8 of the PRMP MCO contract states that the MCO must complete, monitor, and routinely update a treatment plan for each Enrollee who is registered for Special Coverage at least every 12 months, or when the Enrollee's circumstances or needs change significantly, or at the request of the Enrollee. In the event an Enrollee qualifies for both Special Coverage and the HCHN Program, the treatment plan developed under the HCHN program must comply with this provision. MMM referenced and provided the CM Programs P&P, illustrating how CM will be available for Enrollees identified as HCHN and Enrollees registered in Special Coverage as well as outlined the process for CM Programs to be provided according to Enrollee Acuity Level, through CM, Complex Case Management, or the Prenatal Program, facilitating Enrollee care level transitions as their individual needs change. However, Mercer was unable to locate language in P&P providing guidance on support of beneficiaries that are eligible for both Special Coverage and HCHN, or the treatment planning requirements when Enrollees qualify for both programs.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that provide: Details and support of an ongoing source of care for Enrollees appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee. The process for the MCO to provide information to the Enrollee on how to contact their designated person or entity. Coordination efforts P&Ps shall include consultation with Enrollee's PCP. Instructions to Enrollees and Potential Enrollees in the Enrollee Handbook and notices approved by ASES on how to access continued services pursuant to its transition of care process (42 C.F.R. § 438.208) (7.8.2.5) (7.8.2.4.6) (42 C.F.R. § 438.62) (6.1.8) (Amendment A)	Partially Met	MMM provided P&Ps defining the HCHN program, Special Coverage, and CM Scope that includes eligibility, and how the CM programs are provided as well as the Beneficiary Manual illustrating the process for the CM team to create a plan and review the plan at least once a year, if health needs change, or if Enrollee requests a review. Mercer was unable to find language describing how Enrollees can access continued services for the transition of care process.	Revise language in the Beneficiary Manual to ensure that members have information regarding how to access continued services pursuant to the transition of care process.
The MCO has P&Ps on: Coordination of care that actively links the Enrollee to providers, medical services, residential, social, and other support services, including coordination of care between MCOs, settings of care and discharge planning for short and long-term hospital and institutional stays, and from	Partially Met	MMM provided P&Ps illustrating the process for Telepsychiatry for MH and substance use programs and services, including the Integrated MH department's toll-free number for 24/7 access to services, and identification of priority populations for telepsychiatry. P&Ps	Revise or develop P&Ps that describes the availability of Telehealth and Telemedicine for PH services and addresses the availability of Teledentistry services.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
community and social support providers. The availability of healthcare services through Telehealth, Telemedicine, and Teledentistry. (42 C.F.R. § 438.208(b)(2)) (7.8.2.3.7) (7.1.6 Amendment M)		also included the Telehealth platform technical components such as user management, trouble shooting, and monitoring for compliance to ensure quality services. However, Mercer was unable to find documents supporting the availability of telehealth and Telemedicine for PH supports, or any language addressing the use of Teledentistry.	
The MCO has P&Ps that include: Treatment plans be developed by the Enrollee's PCP, with the Enrollee's participation, and in consultation with, any specialists caring for the Enrollee; Treatment plans and are reviewed and revised at least every 12 months, when needs change significantly, or at the request of the Enrollee; and include treatment plan elements as described in 7.8.2.4 of the MCO contract. Processes in the event an Enrollee qualifies for both Special Coverage and the HCHN Program, where the treatment plan developed under the HCHN program must comply with the Special Coverage provisions.	Partially Met	MMM provided P&Ps addressing the identification of and high intensity CM of Enrollees qualifying for Special Coverage and HCHN Programs. Mercer was unable to locate P&P language addressing when an Enrollee qualifies for both Special Coverage and the HCHN Program and the treatment plan developed under the HCHN Program must comply with the Special Coverage provisions.	Revise or develop P&Ps that provides processes in the event an Enrollee qualifies for both Special Coverage and HCHN program, including where the treatment plan is developed under the HCHN program and complies with Special Coverage provisions.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
(42 CFR § 438.208(c)) (7.7.8) (7.7.8.1)			

Utilization Management

A review of UM covered the following areas:

- Coverage and authorization of services
- Compensation for UM activities
- Emergency and post-stabilization services
- Timeframes for authorization decisions
- Prescription drug authorization requirements
- Adverse benefit determination

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MCO, with input from providers, has clinical practice guidelines in place that reflect the needs of Enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MCO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the Enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MCO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through on-site meetings held

November 7, 2023. The on-site meetings involved participation from MCO key leadership including, but not limited to:

- Corporate Medical Director of MH
- Compliance Specialist
- Chief Clinical Operating Officer
- AVP MH Operations
- Director of Outpatient UM
- Pre-Authorization Manager
- Director CM
- Discharge Planner
- VP Pharmacy Services
- AVP Pharmacy Services

Overall Assessment

The MMM UM department provides prior authorization, concurrent, retrospective reviews, and discharge planning. UM decision making, timeframes and timeliness for specified services are well defined through the UM program description and P&P's and the UM program description is updated annually.

The CMO has oversight of the UM department. The Preauthorization UM staff consists of 24 FTEs that include clinical and non-clinical personnel. Directors, managers, and supervisors monitor daily functions using reports and auditing files and documentation. Pre-authorization requests are received by a Provider portal and fax and non-clinical staff refer cases to nursing staff to determine if medical necessity criteria is met. All medical decisions are evaluated by licensed clinical personnel and only physicians make adverse determinations. Determination is communicated to the provider and member both verbally and written.

The Integrated MH Department consists of 32 staff conducting on-site UM review at 11 inpatient facilities and completes telephonic review for partial hospitalization program (PHP) and intensive outpatient program (IOP). Qualifications for clinical positions include, registered nurses with psychiatric nursing experience, Master of Social Work, and Senior level Psychiatrists with licensure in Puerto Rico.

MMM delegates inpatient UM review to in Health Management, LLC. Responsibilities include inpatient concurrent and retrospective review and authorization of hospital stays at acute and subacute levels. MMM does not delegate any UM clinical decision making.

MMM utilizes CMS National Coverage Determinations and Local Coverage Determinations, ASES normative letters and MCG as the guidelines for medical determinations. Monitoring for compliance is conducted by reviewing the ending case report, three times daily, the Turnaround Time report daily as well as the Internal quality monitoring and compliance monitoring. IRR for medical directors and pharmacy staff is 85% and 80% for staff in BH.

Pharmacy authorizations are received via fax, email, or walk-in. All Pre-authorizations are processed within 24 hours after all required information is received for the request. A written decision is provided to the member by mail within three days and also provided to the pharmacy and prescriber within three business days. MMM does review requests to determine if medication is needed in an emergency and when a 72-hour supply can be provided.

The Pharmacy staff consist of doctoral in medicine and pharmacy currently with nine management staff, two coverage determination pharmacists and 19 pharmacy technicians.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has written UM P&Ps to assist Enrollees and providers to ensure appropriate utilization of resources. The MCO's P&Ps reflect the subcomponents listed under 11.2.1 of the GHP contract. (42 C.F.R. § 438.210(a)(3 and 4) and 42 C.F.R. § 438.210(b))	Partially met	The MCO's P&Ps do not reflect the subcomponents listed under 11.2.1 of the GHP contract which address relapse and crisis prevention.	Develop a P&Ps that includes all requirements in 11.2.1 and specifically addresses 11.2.1.7(42 C.F.R. § 438.210(a)(3 and 4) and 42 C.F.R. § 438.210(b)) regarding relapse and crisis prevention.

G&A

A review of G&A covered the following areas:

- General grievance system requirements, including:
  - Information about the grievance systems shared with providers and subcontractors
  - Grievance system P&Ps
  - Authority to file
  - Handling of G&A
  - Recordkeeping requirements
- Grievance system management, including the grievance process and resolution and notification
- Appeals process management, including the appeals process and resolution and notification

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MAO has in effect a grievance and appeal system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MCO must inform members of how to access the grievance system, the availability of the MCO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MCO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MCO provides NOABD letters that are compliant with language, content, and format as required by Enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MCO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MCO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MCO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MCO must keep a log of all G&As filed. The MCO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on

information submitted by the MCO through the RFI and through on-site meetings held November 7, 2023. The on-site meetings involved participation from MCO key leadership including, but not limited to:

- CMO, MMM Healthcare
- Director, G&A
- Manager, G&A

Overall Assessment

The grievance system follows standard processes. Complaints, grievances, and appeals can be received from members, member representatives, or providers verbally through Member Services, in person at a service center, or be written (i.e., filling out a form on the MMM website and submitting it). If a grievance is received verbally, an analyst registers the request in the OnBase system which is then routed to the G&A department. This system is a repository for all Member complaints, grievances, and appeals received and is used to track compliance with documentation and timeliness requirements. During the on-site interview, MMM described the process for receiving complaints, grievances, and appeals (requests) verbally from a member and explained that a written request is not required to begin investigation. Although this practice is compliant with federal regulations, it is contradictory to their P&P as noted in the table below. MMM acknowledged the discrepancy and began a change process to update the P&P. There are 19 FTEs dedicated to the Puerto Rico Medicaid line of business for grievance system management.

The Grievance Coordinator facilitates the grievance investigation, including coordinating investigations with other impacted business units. For example, the PNM team will be sent quality of service grievances; QOC issues are investigated by a clinical provider. Any information that is sent to or received from other units of MMM during the investigation is documented in OnBase. The 90-day timeline for resolving a grievance begins when the MCO receives the initial request (complaint or grievance). At the completion of the investigation, the Grievance Coordinator sends a resolution letter to the member within two business days of the resolution. If a grievance is filed on behalf of the member (provider or representative), an authorization of representation is required for the grievance to be investigated. Grievances provide the MCO with valuable data to support systematic improvements in the QOC and services provided to Medicaid members. There is an opportunity for the MCO to enhance continuous improvement efforts by (informally) investigating all grievances received.

Member complaints are received, documented, and resolved by Member Services within 72 hours of the initial call. If a complaint is not able to be resolved within 72 hours, it is referred to the G&A department for investigation and resolution. Complaint data is aggregated with grievance data and shared with appropriate operational areas to identify continuous improvement opportunities.

Similar to grievances, standard appeals are accepted both verbally through Member Services or in writing (the Appeals Form can be found on the MMM website and at Service Centers) and sent to MMM via US mail, fax, or email. Appeals filed by providers are required to have written member consent. The appeal start date is the date the initial (verbal or written) appeal is received.

Appeals staff are responsible for sending out member correspondence including the initial acknowledgement letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuity of care is requested in the appeal, the G&A analyst checks to ensure the proper steps have occurred and timelines are met. The member or member representative has the opportunity to present the case and answer any questions. The case is deliberated, and a decision is issued and communicated to the member verbally and in writing.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO's P&Ps, Enrollee Handbook, and Provider Manual clearly state that an Enrollee may file an appeal verbally or in writing within 60 calendar days after receiving an Adverse Benefit Determination and will acknowledge receipt of the appeal within 10 calendar days. (42 CFR §438.402 (2)(ii)) (GHP 14.3.3, 14.5.2, 14.5.4)	Not Met	Member and provider materials and MCO P&Ps contain inaccurate requirement for filing a verbal appeal that includes the need for a written appeal within 10 business days.	Review and update G&A P&Ps and member and provider materials to align with 42 CFR §438.402 (3)(ii).
The MCO's P&Ps explain the process to inform the Enrollee of their right to and procedures for requesting an ALH. (GHP 14.6) (42 CFR §438.408(f)) (Act 72 of Sept 7, 1993) (5.3.2.2.3) (5.3.3.3.3) (5.3.4.9) (6.1.1.4) (6.4.5.27.5)	Partially Met	Member and provider materials and MCO P&Ps do not contain information about how and when a member can request an ALH including when it is deemed the appeals process has been exhausted.	Review and update P&Ps and member and provider materials to align with 14.6.1 of the contract. Provide training to MCO staff on updates as needed.

QAPI Program

A review of the QAPI program includes the following:

- The presence of an ongoing comprehensive QAPI program
- Monitoring and assessment of the QAPI
- Analysis and reporting of the QAPI

- Performance measurement
- PIPs

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MAO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to , utilization, claims, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330.

The intent of this regulation is to ensure the MCO has an ongoing quality assessment and PIP for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with SHCN.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through on-site meetings held November 7, 2023. The on-site meetings involved participation from MCO key leadership including, but not limited to:

- VP of QM
- Associate VP of QM
- Staff VP of QM
- QM Director
- QM Supervisor

Overall Assessment

Mercer found all required documentation provided evidence of compliance with regulatory or contractual provisions. During the on-site review, Mercer also observed MMM staff provided responses that were consistent with each other and with the submitted documentation.

The Mercer assessment further found that MMM has comprehensive P&Ps and work plans to support its QAPI activities and oversight responsibilities. MMM illustrates a thorough, comprehensive program that utilizes detailed P&Ps to describe its approach with QOC, UM, continuous QI, provider education, credentialing, and its Quality Improvement Committee (QIC). Quality P&Ps are reviewed annually, at a minimum, and incorporate stakeholder feedback. MMM's quality P&Ps detail the methodology used to monitor, analyze, evaluate, and improve the delivery, quality and appropriateness of healthcare offered to their

members, including those with special needs. P&Ps also clearly define the Advisory Board's responsibility of ensuring all member issues and concerns are heard and addressed appropriately.

Additionally, MMM integrates data from multiple sources to track and trend the quality of healthcare offered to their members. MMM has developed a surveillance program for monitoring, reviewing, and analyzing data to detect over, under and inappropriate utilization of services. Monitoring and reviewing of data are performed on a quarterly basis and include evaluating the need for interventions to improve performance and/or address barriers. MMM utilizes various audit tools for quarterly reporting and stated that 99% of 512 audits performed had a passing rate.

Lastly, MMM, through its QAPI Program, has established a PIP work plan, a comprehensive process for PIP development, and methodology used for evaluation to determine performance and improvement. MMM's process includes a description of its approach to oversight and monitoring, including reporting and data collection, with the QM Supervisor responsible for the oversight of the PIPs as well as presenting the results to the QIC. MMM's work plan outlines measurable objectives, actions steps, cadence for meeting and reporting, and responsible parties for various quality issues related to these performance activities.

Findings

MMM met all requirements for these metrics through RFI documents, on-site discussions, and post on-site submissions.

PSM

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of PSM's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual meetings held November 8, 2023. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- Executive VP
- VP, Clinical Affairs
- SVP Clinical Affairs
- VP, Medical Affairs
- Senior VP, Clinical Management
- CMO
- Provider Director, Assistant VP
- Chief Legal Counsel

- Delegation Oversight Director
- Health Education Director
- UM Director
- Compliance Officer
- Quality Assurance Director
- IT Director
- Claims Configuration Director
- Health Education and Wellness Director
- UM Director, APS
- Provider Director, APS
- Manager, Quality APS
- Supervisor, G&A APS

Strengths

PSM had a strong strategic PM reporting team, specializing in efficient data collection capabilities, report analysis, timely problem solving, and knowledge of any new industry standards.

PSM conducts additional special claim audits designed to support the claims, configuration and payment integrity, and cost savings operations. The robust audit processes are fundamental to ensuring the accuracy of the claims processing and payments as well as overall improvement in PI and claims operations.

Opportunities for Improvement

PSM has an opportunity to analyze appeal data to identify trends and conduct provider outreach and education on PA documentation needed to reduce the number of appeals and subsequently ensure members receive services timely without creating additional burden to the member.

PSM has an opportunity to enhance PIP Aim Statements by clearly defining the improvement strategy, target population, measurable impact, and time period within each PIP structure, as well as demonstrate continuous QI techniques within the PIP evaluation process.

Recommendations

The APS UM policies are written for Commercial, Medicaid, and Medicare lines of business. It is recommended that PSM review to determine if the language can be revised for clarity with each line of business.

It is recommended that PSM develop Aim Statements that are clear, concise, measurable, and answerable, as well as adopt and implement continuous QI methodologies with the PIP process.

PSM staff stated that PSM does not use taxonomy codes. It is recommended that PSM review its P&Ps for collecting and using the taxonomy codes to align with CMS expectations.

Administration and Organization

Overview

Organizational Structure

PSM's organizational structure is led by an executive leadership team comprised of the Finance Department, the CMO, the Administrative Officer, IT and Claims, the Chief Legal Plan Counselor, and the MSO. The CMO oversees the Medical and Payment Policy teams, Pharmacy, UM, Education, and CM programs. G&A and quality assurance management are under the Chief Legal Plan Counselor and the Administrative Officer oversees compliance, delegation, the service and call centers and enrollment. The MSO oversees network management and PMG administration. PSM departments range in size from five staff in G&A to 48 in Customer Service. PSM offers both Platino and commercial lines of business in Puerto Rico. All PSM employees are fully dedicated to Puerto Rico.

Delegated Entities

PSM delegates responsibilities to seven different entities outlined in the table below.

Delegated Entity	Type of Entity and Services
Agilerta	Network — Credentialing and recredentialing
APS Healthcare of Puerto Rico	MH — MH benefits, MH provider network credentialing and recredentialing, MH claims and processing and payment, pharmacy services, MH quality and UM services, BH CM, MH and pharmacy G&A, MH education, reporting, MH Enrollee, and provider call center.
Delta Dental of Puerto Rico	Dental services — PNM including credentialing and recredentialing, claims processing and payment, call center, reporting, management of dental services complaints, G&A, and provider disputes.
Humana Health Plans of Puerto Rico	Health plan — Eligibility and enrollment (including ID cards), benefits and covered services, claims processing support, reporting, UM clinical platform, financial recovery services including pre- and post-payment audits, special investigations unit, FWA, and code edits.

Delegated Entity	Type of Entity and Services
Jaye, Inc (Telemedik)	Call center services for providers and beneficiaries, nurse advisory line, and reporting.
LinkActiv	Call center services for providers and beneficiaries and reporting.
Provider Network Solutions (PNS) of Puerto Rico	Network services — Network management and reporting.

PSM has P&Ps in place which operationalize the monitoring, oversight and auditing of delegated entities and has a dedicated unit, the Delegation Oversight team, which is responsible for all subcontractor oversight activities. PSM utilizes a two-tier monitoring process. The first tier monitors day-to-day activities of operational areas. Second tier monitoring focuses on regulatory, contractual requirements, and performance guarantees. PSM's policies indicate that PSM allows for sub-delegation under delegated entities.

Accreditation

PSM has an active URAC accreditation and completed the re-accreditation process in August 2020 and September 2022.

Employee Training

All PSM employees receive training on advance directives, cultural competency, FWA, HIPAA, and an overview of Medicaid. Customer service center staff and employees in the Enrollment and G&A Departments also receive training on Enrollee rights, grievances, and appeals. PSM also trains subcontractors on some or all of these training topics.

Enrollee Rights and Protections

A review of Enrollee rights and protections covered the following areas:

- Disenrollment requirements and limitations
- Enrollee rights requirements, including Enrollee rights and responsibilities, advance directives, the right to receive information, and moral and religious objections
- Information requirements for Enrollees

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MCO complies with the State enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MCO has written policies related to Enrollee rights and ensure the MCO complies and holds staff and affiliated providers accountable to comply with Enrollee rights and applicable State and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 438.10.

The intent of these regulations is to ensure the MCO provides appropriate information to Enrollees and potential Enrollees in a language and format that is easily understood. The MCO must inform Enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific Enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MCO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (j).

The intent of these regulations is to ensure the MCO maintains P&Ps related to advance directives, including their rights under State law, and must contain clear and concise language on the limitation if the MCO cannot implement an advance directive as a matter of conscience. The MCO is responsible for providing Enrollees with periodic written information regarding advance directives and their rights under the State laws. The MCO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MCO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MCO is responsible for ensuring Enrollees have the right to participate in decisions regarding their care, to be free from any form of restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MCO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, and limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements for Enrollee rights and protections, Mercer conducted a thorough review of PSM's Enrollee facing materials, employee training materials pertaining to Enrollee rights, associated P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through a virtual meeting held on November 8, 2023. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- Executive VP
- Delegation Oversight Director
- Marketing Manager
- Customer Service Manager
- Enrollment Manager

- IT Manager
- Health Education Director
- Health Education Team Lead

Overall Assessment

Disenrollment Requirements and Limitations

PSM has a strong process in place to comply with CFR and contractual requirement pertaining to Enrollee disenrollments. P&Ps indicate that disenrollment occurs only when the Medicaid Program determines that an Enrollee is no longer eligible for the health plan, or when disenrollment is requested by the Contractor or Enrollee and approved by ASES. PSM notifies Enrollees annually of their disenrollment rights and the plan's P&Ps show that Enrollees are notified of the availability of the grievance system and ASES' ALH process when the request for disenrollment is initiated by the plan.

Enrollees may request disenrollment from the plan without cause once during the applicable Open Enrollment Period. Enrollees are also notified of grievance and administrative hearing rights and procedures, as indicated in PSM's P&Ps, and as notified through the Enrollee handbook and the plan's website. Lastly, PSM has P&Ps in place to adjust disenrollment effective dates for Enrollees who are either hospitalized, pregnant, in the appeal process and/or within a month when a terminal diagnosis was made.

Enrollee Rights Requirements

Regarding Enrollee rights, PSM notifies Enrollees of their rights to request and receive information within the Enrollee handbook and trains employees of these rights at hire and annually thereafter. However, PSM has not operationalized these requirements within P&Ps. PSM will need to develop a P&P outlining Enrollee rights to request and receive information in accordance with CFR and contractual requirements.

Regarding advance directives, PSM informs Enrollees about advance directives in the Enrollee handbook and also displays informational posters about advance care planning in service centers and in PCP offices, However, at the time of the review, PSM did not have a P&P in place regarding Enrollee rights pertinent to advance directives, the reading level requirements, and the age at which Enrollees should receive information about advance directives. PSM will need to develop a P&P pertaining to advance directives which meets all requirements in accordance with CFR and contract requirements.

PSM does not currently have a process in place to guide providers and Enrollees when a provider issues a moral or religious objection to cover, reimburse, refer, or issue PA any service with the scope of the detailed covered services. PSM will need to develop clear guidance to providers regarding notification requirements to the plan, ASES and Enrollees when providers issue a moral or religious objection.

Information Requirements for Enrollees

PSM adheres to all CFR and contractual requirements pertaining to Enrollee information requirements and utilizes ASES' Universal Beneficiary Guide as a model that includes all contractual requirements for the Enrollee handbook. PSM's P&Ps meet all requirements

pertaining to the development and distribution of written materials in alternative formats and language based upon the needs of the Enrollee. There are clear procedures to develop/create, proof, submit and obtain ASES written approval, publish and/or mail the Enrollee ID card, Enrollee Handbook, Provider Directory, and form letters within contractual standards and timeframes. PSM also ensures that written Enrollee informational and instructional materials meet the language and format requirements outlined in contract standards. When written materials are requested in alternative formats, policies dictate that the generation of these materials take into consideration the Enrollee's special needs and Enrollees are informed on how to access those formats. Finally, PSM has P&Ps indicating that Enrollees must be provided with at least 30 calendar days written notice of any significant change in policies concerning Enrollee rights, their right to change PMG or PCP or any of the other items listed as Enrollee rights in the contract.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that comply with: written at a fourth grade reading level in English and Spanish; provided to Enrollees 18 years of age and older; (7.10.1) advise Enrollees of their rights under the laws of Puerto Rico to accept or refuse medical or surgical treatment and the right to formulate Advance Directives; the implementation of those rights, including a statement of any limitation regarding implementation of Advance Directives as a matter of conscience; and the Enrollee's right to file complaint or grievance concerning noncompliance with Advance Directive requirements directly with ASES or with the Puerto Rico Office of the Patient Advocate. (14.9) The P&Ps reflect a description of Puerto Rico law and requires the MCO to reflect changes in laws as soon as possible and no later than 90 calendar days after the effective change (7.10). (42 C.F.R. § 438.3(j)), 42 CFR 422.128(a), 42 CFR.128(b),	Partially Met	The plan does not have a P&P in place which speaks to the specific Enrollee rights pertinent to advance directives, the reading level requirements and the age at which Enrollees should receive information about advance directives.	Develop a P&P pertaining to advance directives which meets all requirements set forth in Sections 14.9, 7.10 and 7.10.1 of the contract and in accordance with 42 C.F.R. § 438.3(j)), 42 CFR 422.128(a), 42 CFR.128(b), 42 CFR 489.102(a), and Law No. 160 of Nov 17, 2001.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
42 CFR 489.102(a), and Law No. 160 of Nov 17, 2001.			
The MCO has P&Ps that ensure that a provider acting within the lawful scope of practice is not prohibited from advising or advocating on behalf of an Enrollee for the Enrollee's health status, medical care, or treatment or non-treatment options and includes this provision in its provider contracts (10.3.1.15). (42 C.F.R. § 438.102(a)) The MCO P&Ps for the Enrollee rights to receive information are pursuant to 42 CFR 438.10, and complies with Section 6.5.	Partially Met.	The plan addresses Enrollee rights to request and receive information in their employee training and within the Enrollee handbook. However, the plan has not operationalized these requirements within a P&P.	Develop a P&P outlining Enrollee rights to request and receive information, pursuant to 42 CFR 438.10, and Section 6.5 of the contract.
The MCO has P&Ps that describe the use of any moral or religious objections to cover, reimburse, refer, or PA any service with the scope of the detailed covered services. The P&Ps include notification to ASES, Enrollees, and potential Enrollees as provided in 7.13.1 of the contract. (42 C.F.R. § 438.102(b) and 42 C.F.R. § 438.10(g)(2)(ii)(A and B)) The MCO has P&Ps that permit the Enrollee to change PCP due to moral or religious conflict. (5.4.1.5.1)	Not Met.	The plan did not provide any P&Ps or other evidence showing how the plan guides providers when they have a moral or religious objection or how providers should notify the plan, ASES and Enrollees of these objections.	Develop clear guidance to providers regarding notification requirements to the plan, ASES and Enrollees when providers issue a moral or religious objection. Guidance may be within Provider Guidelines and/or associated P&Ps.

Provider Network — Access and Availability

A review of the provider network covered the following areas:

- Availability of services
- Furnishing of services and timely access
- Access and cultural considerations
- Assurances of adequate capacity and services

- Provider credentialing
- Sub-contractual relationships and delegation
- Practice guidelines

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MCO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MCO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MCO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MCO has written P&Ps for the selection and retention of providers and a documented process for the initial and recredentialing of providers. Regulation 438.214(c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214(d) prohibits the MCO from contracting with providers that are excluded from participation in Medicare and State healthcare programs.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with State requirements. The MCO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network.

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MCO has P&Ps in place which guarantee the MCO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MCO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The intent of these regulations is to ensure the MCO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MCO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers, and financial considerations.

The following federal regulation is addressed in this section: 438.104.

The intent of this regulation is to ensure the MCO obtains State approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of PSM's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual meetings held November 8, 2023. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- Provider Director, AVP
- Provider Manager, Delta Dental
- Provider Director, APS
- Provider Education Specialist
- Specialist Configuration
- Human Resource Technician

Overall Assessment

Mercer found that much of the required documentation was present, MCO staff provided responses that were consistent with each other and with the documentation, or a state defined percentage of all data sources provided evidence of compliance with regulatory or contractual provisions. Through virtual review discussions, it seemed that, for the areas where documentation was not present, PSM had processes in place to meet the requirements, however these processes were not found in P&Ps, standard operating procedures (SOPs), or workflows.

PSM submitted the Provider Network Development and Management Plan period for CY 2023. The plan encompasses ensuring Enrollee access to services by outlining standards for provider ratios, facility locations, and time-distance requirements within specified municipalities as well as the monitoring activities to guarantee these access standards are consistently met. It details network providers' capacity issues, quality management/improvement activities, and their targeted completion dates. It also identifies network deficiencies in services and geographical areas, proposing interventions to address these gaps. The ongoing network development and expansion efforts consider current provider capacity, network deficiencies, service delivery issues, and future needs. PSM did not provide specific P&Ps from APS that directly address the process to ensure access to BH-covered services.

The PSM Provider Directory includes the following available fields: name, specialty, group affiliation, locations, office hours, phone numbers, websites, cultural and linguistic capabilities, accommodation for people with disabilities, and identification of providers in the network who are accepting new patients. All PCPs and preferred networks are grouped by PMG and the Provider Directory is organized alphabetically and by specialty. The directory does not include if the provider completed cultural competency training as contractually required, however, PSM has plans to update the directory to include this field. PSM provided the process to update the provider directory with any changes and include the oversite process.

PSM delegates credentialing and re-credentialing to PNS and submitted the PNS delegation agreement and accompanying PNS P&Ps, thoroughly describing the contracting and credentialing process. PSM reports using the Puerto Rico Medicaid Provider Enrollment Portal to ensure that providers are enrolled as a Medicaid provider. The Credentialing Committee provides oversight of the process and states that all Credential Committee processes and decisions shall be conducted in accordance with applicable state and federal laws and national guidelines. The Credential Committee includes seven members (providers) appointed by the CMO.

PSM submitted the SOP for the provider termination process that is applicable to both Plan Vital and Commercial (Non-PCP) PSM Enrollees, describing the management of client termination requests, terminations identified by PNS, the cancellation process initiated by providers, examples of termination instances in client service contracts, and the provider termination logbook. However, the SOP lacks a specified process for informing ASES of provider terminations, a requirement under Contract Requirement 18.2.5.4. The submitted documentation did not include the Agilerta delegation agreements or a clear explanation on the process to determine when Agilerta versus PNS perform credentialing tasks.

PSM submitted the Plan Vital Provider Handbook that includes the contractually required topics for provider guidelines. The handbook includes a section for EPSDT Program. The section encompasses information related to well-child check-up visits, with components including:

- Comprehensive health and developmental history, including assessment of physical, behavioral, and nutritional conditions.
- Developmental screening using a recognized, standardized developmental screening tool approved by ASES.
- Developmental screening for social-emotional conditions, using a recognized and standardized developmental screening tool approved by ASES.

The Handbook details PSM’s initiatives in Provider Outreach and Education Regarding EPSDT, providing education to Beneficiaries and Providers about the EPSDT Program components. The Handbook also emphasizes the training of Providers to ensure that evidence-based practice guidelines are followed and that the services and care for children with chronic and special conditions comply with those in the guidelines. It also includes Provider referral of children for further diagnostic and treatment services to correct or ameliorate defects, PH and mental illnesses, and conditions discovered by the EPSDT checkup. However, neither the provider contracts, nor other documentation provided

evidence of requiring PCP adherence to administering the Modified Checklist for Autism in Toddlers (M-CHAT R/F) screening tool, following the "Protocolo Uniforme de TEA" government plan version, published by the Department of Health, or Ages and Stages Questionnaire (ASQ), or its alternative, the Survey of Well-being of Young Children (SWYC) to the parents of child Enrollees, as required in the Plan Vital Contract.

For oversight and monitoring of the network, PSM submitted the process for monitoring appointment availability and geo-access reporting. Provider site evaluations are performed and the tool screens for contractual requirement, with the following sections: appointment availability, accessibility (including for disabilities), office appearance, office staff, office operational procedures, work safety, and OSHA compliance. Network exceptions are documented and updated to provide a tracking mechanism on areas of provider network needs.

PSM provides comprehensive provider training for both team members and subcontractors. Training topics include advance directives, cultural competency, FWA, HIPAA, privacy, confidentiality, BH, Enrollee rights, G&A, and a Medicaid overview, including covered services, medical billing, and coding. PSM coordinates with the other Plan Vital MCOs to provide contractually required provider trainings in a streamlined manner.

The Cultural Competency Plan 2023 features a section dedicated to ensuring the contracting of providers from diverse cultures, detailing various strategies and interventions. It emphasizes organizational commitment to cultural competency, including clearly communicating its importance and allocating necessary resources for implementation. Staff receive training on the proper use of interpreters; bilingual services are in place to overcome language barriers and provide qualified interpreters through various methods. PSM offers cultural competency training for providers in all aspects of patient care and administration, aiming to improve cross-cultural communication and promote equitable healthcare delivery.

Provider Type	2022 Number of Providers
PCP	1502
PMG	87
Hospital	65
Urgent Care	6
Nursing Facility	1
Dental	651
Vision	304
BH	1017
FQHC	19

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has a provider Directory in place and P&Ps describing how the provider directory is accessible, updated, frequency of updates and validation of information in its provider directory, including the data elements listed in Section 6.6. (42 C.F.R. § 438.10(h)) (6.10.1, 6.10.8 Amendment A, 6.10.9)	Partially Met.	The PSM Provider Directory includes all includes the following available fields: name, specialty, group affiliation, locations, office hours, phone numbers, websites, cultural and linguistic capabilities, accommodation for people with disabilities and identification of providers in the network who are accepting new patients. The directory does not include if the provider completed cultural competency training as contractually required.	Update the provider directory to include a notation that a provider completed cultural competency training.
The MCO's provider recruitment P&Ps include effective strategies to ensure adequate access to all covered services in accordance with Puerto Rico's access standards that include appointment availability timeframes for non-urgent/urgent conditions, access to services for Enrollees with special healthcare conditions, monitors providers hours of services including BH and PMG providers. (9.5.1-5) Medicaid: (42 C.F.R. § 438.206(c)(1)) & CHIP: (42 CFR § 457.1230(a)) (Attachment 2 and 20) (42 CFR 438.68) (18.3.1.7)	Partially Met.	APS P&Ps that specifically outline the process for ensuring access to BH-covered services were not included in the initial nor the follow-up submission.	Provide specific APS P&Ps to ensure Enrollees have access to BH-covered services.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has P&Ps to ensure provider contracts comply with 10.3 and Amendments A and M of the contract. Including contract compliance with Autism context in 7.7.9. (7.1.18) (7.7.9.2) (9.2.3.7) (10.1.6) (10.3)	Partially Met.	Neither the provider contracts, nor other documentation provided evidence of requiring PCP adherence to administering the M-CHAT R/F screening tool, following the "Protocolo Uniforme de TEA" government plan version, published by the Department of Health, or the ASQ, or its alternative, the SWYC to the parents of child Enrollees. as required in the Plan Vital Contract.	Provide documentation requiring PCP adherence to administering the M-CHAT R/F screening tool, following the "Protocolo Uniforme de TEA" government plan version, published by the Department of Health and administering to the parents of child Enrollees, the ASQ, or in the alternative, the SWYC as required in 7.7.9.2-7.7.9.3.
The MCOs have written P&P for provider termination that comply with 10.4 and reporting of provider terminations and suspensions. (18.2.5.4)	Partially Met.	PSM submitted the SOP CO-S-007 for Provider Termination Process — Vital and Commercial (Non-PCP),' which covering an overview of how to handle client termination requests, terminations identified by PNS, the cancellation process initiated by providers, examples of termination instances in client service contracts, and the provider termination logbook. However, the SOP lacks a specified process for informing ASES of provider terminations, a requirement under Contract Requirement 18.2.5.4.	Revise the Provider Termination Process SOP document to address the reporting requirements to ASES within the required timeframes. Develop a process to track and report within the contractual timeframes.
The MCOs have P&Ps in place for subcontractor relationships (Article 30) Medicaid. (42 C.F.R. §	Partially Met.	PSM submitted delegation agreements and supporting documents for PNS that	Provide clear explanation on sub-delegation activities, including the process to determine

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
438.230), CHIP: (42 C.F.R. § 457.1233(b))		includes credentialing and re-credentialing. The document submission did not include agreements for Agilerta.	when Agilerta versus PNS perform credentialing tasks. Provide Agilerta delegation agreements.

Coordination and Continuity of Care

A review of the coordination and continuity of care covered the following areas:

- Identification of populations with SHCN
- Enrollee monitoring for medical conditions suggesting a need for care or disease management
- Protection of Enrollee records from unauthorized disclosure per the HIPAA Privacy and Security standards

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MCO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to Enrollees with special healthcare needs, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated CC program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize QOC and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MCO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of PSM's organizational charts, training materials,

P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual meetings held November 8, 2023. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- VP, Clinical Affairs
- Senior VP, Clinical Management
- CMO
- UM Director
- UM Manager
- Health Education and Wellness Director
- Program Manager
- Care Manager Supervisor
- Care Manager
- Executive Assistant
- Pharmacy Manger
- Pharmacist
- UM Preauthorization Nurse

Overall Assessment

Mercer found PSM documentation provided evidence of compliance for some, but not all, of the regulatory or contractual provisions.

PSM staff provided P&Ps that detailed strategies utilized to reach an 85% enrollment rate in their wellness plan including advertisements, campaigns, seminars, health fairs, educational activities, telephonic educational interventions, and face to face visits with Enrollees. They routinely analyze PMs and coordinate with the quality department to ensure they are tracking educational topics covered. The P&Ps ensure that educational activities are facilitated by appropriately trained and/or licensed staff and the topics are within the staff's scope of practice. Policies included ensuring that education was provided on the importance of preventive care, immunizations, self-care, annual health visits, and completing annual dental exams. The policies also spoke to collaboration with PMGs, specialized medical homes, Multidisciplinary Care Team members, government agencies, community centers, and Community Healthcare Workers when planning and offering health education programs as well as leveraging these connections to reach members in rural areas.

PSM policies illustrated processes for the Care Coordination team to collaborate with the Quality Department to identify and complete all auditing and monitoring requirements. The policies also outline steps to ensure that all PRMP and ASES quality reporting is complete and submitted within the contractually required timeframe. PSM demonstrated processes for

care coordination supervisors, using random record sampling, to conduct quarterly audits of care coordination cases using the following criteria; unable to contact/decline process and completion of assessments, individualized care plans, notes, and tasks. PSM policies indicate the minimum passing benchmark is set at 80% and outlines required steps to address any areas of improvement.

PSM provided its Beneficiary Manual outlining a high-level description of how the PSM CM program can support members with special conditions or high needs in meeting their health goals and decreasing gaps in service delivery. Mercer was unable to find language in the Beneficiary Manual that explained how a member could access continued services pursuant to PSM's transition of care process per section 6.1.8 of the PRMP MCO contract.

Additionally, PSM provided policy illustrating promotion of access to Care Manager, PCP, and specialized provider visits using alternate visits (telephone/Telehealth/Telemedicine) and detailed its expansion of Telehealth capacity with tablets and providing education to providers and Enrollees about telehealth. Mercer was unable to find PSM Care Coordination policies that addressed the availability and use of Teledentistry.

Section 7.7.8 of the PRMP MCO contract states that the MCO must complete, monitor, and routinely update a treatment plan for each Enrollee who is registered for Special Coverage at least every 12 months, or when the Enrollee's circumstances or needs change significantly, or at the request of the Enrollee. In the event an Enrollee qualifies for both Special Coverage and the HCHN Program, the treatment plan developed under the HCHN program must comply with this provision. PSM's P&P for Special Coverage Protocols ensured that special coverage program eligibility supersedes HCHN Program eligibility. The policy provided processes for when a member qualifies for both programs, special coverage takes the lead in coordinating with others involved in the member's care. However, Mercer was unable to locate language in policy providing guidance on support of beneficiaries that are eligible for both Special Coverage and HCHN and the treatment planning requirements when Enrollees qualify for both programs.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that provide: Details and support of an ongoing source of care for Enrollees appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee. The process for the MCO to provide information to the Enrollee on how to contact their designated person or entity.	Partially Met.	PSM provided documents containing the Enrollee customer service number and the assigned care manager's name as well as a description of how the PSM CM program can support members with special conditions or high needs in	Revise the Beneficiary Manual to include language educating members on how they can access continued services pursuant to the transition of care process.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
Coordination efforts P&Ps shall include consultation with Enrollee's PCP. Instructions to Enrollees and Potential Enrollees in the Enrollee Handbook and notices approved by ASES on how to access continued services pursuant to its transition of care process (42 C.F.R. § 438.208) (7.8.2.5) (7.8.2.4.6) (42 C.F.R. § 438.62) (6.1.8 Amendment A)		meeting their health goals and decreasing gaps in service delivery. Mercer was unable to find language describing how Enrollees can access continued services for the transition of care process.	
The MCO has P&Ps on: Coordination of care that actively links the Enrollee to providers, medical services, residential, social, and other support services, including coordination of care between MCOs, settings of care and discharge planning for short and long-term hospital and institutional stays, and from community and social support providers. The availability of healthcare services through Telehealth, Telemedicine, and Teledentistry. (42 C.F.R. § 438.208(b)(2)) (7.8.2.3.7) (7.1.6 Amendment M)	Partially Met.	PSM provided policy illustrating promotion of access to Care Manager, PCP, and specialized provider visits using alternate visits (telephone/Telehealth/Telemedicine) and detailed its expansion of Telehealth capacity with tablets and providing education to providers and Enrollees about Telehealth. Mercer was unable to find PSM Care Coordination policies that addressed the availability and use of Teledentistry. PSM staff confirmed they do not currently have P&Ps addressing Teledentistry.	Develop a P&P that addresses the availability of healthcare services through Teledentistry.
The MCO has P&Ps that include: Treatment plans be developed by the Enrollee's PCP, with the Enrollee's participation, and in	Partially Met	PSM provided policy addressing Enrollees qualifying for special coverage and HCHN	Revise or develop P&P that details the processes in the event a member

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
consultation with, any specialists caring for the Enrollee; Treatment plans and are reviewed and revised at least every 12 months, when needs change significantly, or at the request of the Enrollee; and include treatment plan elements as described in 7.8.2.4 of the MCO contract. Processes in the event an Enrollee qualifies for both Special Coverage and the HCHN Program, where the treatment plan developed under the HCHN program must comply with the Special Coverage provisions. (42 CFR § 438.208(c)) (7.7.8) (7.7.8.1)		Programs. Mercer was unable to locate policy language addressing when an Enrollee qualifies for both Special Coverage and the HCHN Programs and the treatment plan developed under the HCHN Program must comply with the Special Coverage provisions.	qualifies for both Special Coverage and the HCHN Program, where the treatment plan developed under the HCHN Program must comply with the Special Coverage provisions.

UM

A review of UM covered the following areas:

- Coverage and authorization of services
- Compensation for UM activities
- Emergency and post-stabilization services
- Timeframes for authorization decisions
- Prescription drug authorization requirements
- Adverse benefit determination

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MCO, with input from providers, has clinical practice guidelines in place that reflect the needs of Enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MCO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the Enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MCO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of PSM's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual meetings held November 8, 2023. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- CMO
- UM Director, APS
- SVP, Clinical Affairs
- UM Director
- UM Registered Nurse

Overall Assessment

The PSM UM department provides PA, concurrent, and retrospective reviews. UM decision making, timeframes, and timeliness for specified services are well defined through the UM P&P's and program description which is updated annually.

The CMO has oversight of the UM department which includes two Medical Directors, a UM Director, a UM Manager, a hospital region supervisor, a pre-authorization supervisor, and the coordinators and nurse for each unit. The PA requests are received via fax and email and more urgent needs are relayed via phone or messaging. Pre-authorizations and Concurrent reviews are distributed daily according to caseloads and all staff are trained to complete all service authorizations. PSM uses Change Healthcare InterQual guidelines as its main resource to assist in medical necessity determinations as well as ASES normative letters and other evidence-based guidelines, like National Comprehensive Cancer Network. Monitoring occurs both manually and electronically with dashboards used to oversee work in real time.

APS is fully delegated for all BH UM operations and the PSM Compliance department is responsible for training and monitoring the performance through its Delegation Oversight team. APS policies include language that is compliant with GHP contractual requirements;

however, the polices are written for all lines of business (Commercial, Medicare, and Medicaid) and are difficult to follow at times. It is recommended the policies be reviewed to determine if the language can be revised for clarity. The APS UM committee reports to the PSM Quality committee quarterly. APS utilizes Milliman Care Guidelines for BH and ASES normative letters. Care is coordinated between PSM and APS through the Interdisciplinary Care Team. APS and PSM also use the same platform so that notes can be shared and viewed.

The UM team works in conjunction with Quality Assurance to monitor UM performance as well as detect over, under and inappropriate utilization of services. Average Length of Stay and readmission data are used to identify members who would be appropriate for the Complex Case program. Policies are reviewed on an annual basis and other metrics, such as turnaround times and the inpatient concurrent review rate are reported monthly. IRR is conducted annually with an 80% pass rate.

Mercer found all required documentation was present and MCO staff provided responses that were consistent with each other and the documentation regarding the timeframe for PA decisions, providing written notice of adverse benefit determinations, emergency and post stabilization services do not require a referral or prior authorization, and that staff are not incentivized for making UM decisions.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has written P&Ps that: (i) identify, define, and specify the amount, duration and scope of each covered service and benefit (including any quantitative and non-quantitative treatment limits) to Enrollees consistent with the program requirements of the GHP, Puerto Rico Medicaid State Plan, and CHIP Plan (Article 7 and 7.1.1); (ii) ensure that the services are sufficient in amount, duration or scope to reasonably achieve the purpose for which the services are furnished; (iii) indicate that the MCO does not arbitrarily deny or reduce the amount, duration, or scope of a covered service solely because of the diagnosis, type of illness, or condition (7.1.1); and (iv) define "medically necessary services" consistent with 7.2 of the contract.	Partially Met.	PSM reports that they address parity by covering BH services and ensuring the processes to obtain services are not stricter than on the PH side. They share information with APS around timelines and the number of reviews to conduct, but there is no documented parity P&P or analysis process.	Develop P&Ps to demonstrate adherence to 42 CFR part 438, subpart K and 42 C.F.R.§ 438.910(d) regarding parity in BH services.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
(42 C.F.R. § 440.230, 42 C.F.R. § Part 441, Subpart B, and 42 C.F.R. § 438.210(a)). The MCO has P&Ps to ensure all Enrollees are provided access to a set of services that meets the requirements of 42 CFR part 438, subpart K and 42 C.F.R.§ 438.910(d) regarding parity in BH services, regardless of what BH services are provided by the Contractor. (GHP 7.5.11.6.7 Amendment A)			

G&A

A review of G&A covered the following areas:

- General grievance system requirements, including:
  - Information about the grievance systems shared with providers and subcontractors
  - Grievance system P&Ps
  - Authority to file
  - Handling of G&A
  - Recordkeeping requirements
- Grievance system management, including the grievance process and resolution and notification
- Appeals process management, including the appeals process and resolution and notification

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MCO has in effect a G&A system that meets the requirements of 438.400..

The intent of this regulation is to ensure the MCO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MCO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MCO must inform members of how to access the grievance system, the availability of the MCO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MCO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MCO provides NOABD letters that are compliant with language, content, and format as required by Enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MCO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MCO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MCO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MCO must keep a log of all G&As filed. The MCO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of PSM's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual meetings held November 8, 2023. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- Supervisor, G&A

- Manager, Quality (APS)
- Supervisor, G&A (APS)
- Compliance Officer
- Chief Legal Counsel
- Specialist, G&A
- Specialist, Quality

Overall Assessment

The grievance system follows standard processes. Complaints, grievances, and appeals can be received from members, member representatives, or providers verbally through Member Services, in person at a service center, or be written (i.e., filling out a form on the PSM website and submitting it). If a grievance is received verbally, an analyst registers the request in the Essette system which is then routed to the G&A department. This system is a repository for all Member grievances, and appeals received and is used to track compliance with documentation and timeliness requirements and reporting to ASES and the QI unit on a quarterly basis. Member complaints are managed in Member Services in a different system. It should be noted that the MCO changed systems in 2023 and plans to extend visibility of complaints data to the G&A department in 2024. PSM delegates member complaints, grievances, and appeals related to BH to APS Healthcare who follows the same investigation and resolution process as the MCO and cases are documented in Essette.

The Grievance Coordinator facilitates the grievance investigation, including coordinating investigations with other impacted business units. For example, the PNM team will be sent quality of service grievances; QOC issues are investigated by the clinical and/or quality team. Any information that is sent to or received from other units of PSM during the investigation is documented in Essette. The 90 day timeline for resolving a grievance begins when the MCO receives the initial request (complaint or grievance). At the completion of the investigation, the Grievance Coordinator sends a resolution letter to the member within two business days of the resolution. When three or more grievances are received about the same provider, PNM conducts provider education on the issue(s) and information is added to the provider's quality report that is shared with the credentialing committee.

Member complaints are received, documented, and resolved by Member Services within 72 hours of the initial call. If a complaint is not able to be resolved within 72 hours, it is referred to the G&A department for investigation and resolution. During the review period, complaints data was not aggregated with grievance data.

Similar to grievances, standard appeals are accepted both verbally (through Member Services) or in writing (appeals form can be found on the PSM website and at Service Centers) and sent to PSM via US mail, fax, or email. Verbal appeals filed by the member require a written appeal within 10 days of the verbal request. Following the virtual interview, the MCO submitted a revised policy dated November 13, 2023 that no longer requires a written follow-up. Appeals filed by providers are required to have written member consent. The appeal start date is the date the initial (verbal or written) appeal is received.

Appeals staff are responsible for sending out member correspondence including the initial acknowledgement letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuity of care is requested in the appeal, the G&A analyst checks to ensure the proper steps have occurred and timelines are met. The member or member representative has the opportunity to present the case and answer any questions. The case is deliberated, and a decision is issued and communicated to the member verbally and in writing. For appeals that are overturned, G&A works with the UM unit to approve the service(s) within two business days. In 2022, approximately 80% of adjudicated appeals were overturned due to lack of information during the PA request. It was unclear whether any trends were identified about what types of services were most likely to result in an overturned appeal. There is an opportunity for the MCO to analyze appeal data to identify trends and conduct provider outreach and education on PA documentation needed to reduce the number of appeals and subsequently ensure members receive services timely without creating additional burden to the member.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO's P&Ps, Enrollee Handbook, and Provider Manual clearly state that an Enrollee may file an appeal verbally or in writing within 60 Calendar Days after receiving an Adverse Benefit Determination and will acknowledge receipt of the appeal within 10 calendar days. (42 CFR §438.402 (2)(ii)) (GHP 14.3.3, 14.5.2, 14.5.4)	Partially Met.	The MCO has updated the G&A policy to reflect that a verbal request for an appeal does not need to be followed by a written appeal.	Review and revise member and provider materials to reflect the updated MCO policy. Provide training to MCO staff to ensure the policy change is operationalized as necessary.
The MCO's P&Ps clearly state time frames for standard resolution of appeals and notification of the decision within 30 calendar days. (42 C.F.R. §438.408) Written Notice of Disposition of an appeal is provided to the Enrollee ASES within two business days of the decision. (14.5.14, 14.5.15 and 14.5.9) (Section 14.5 GHP)	Partially Met.	The MCO informs ASES of the number of appeals received, processed, how many were overturned or upheld (in full or in part), reasons for the appeal for PH and BH services, and number of appeals resolved by general service type on a quarterly basis.	Review P&Ps and expectations for informing ASES of appeal decisions within two business days of the resolution according to 14.5.14 of the contract.

QAPI Program

A review of the QAPI program includes the following:

- The presence of an ongoing comprehensive QAPI program
- Monitoring and assessment of the QAPI
- Analysis and reporting of the QAPI
- PM
- PIPs

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to , utilization, claims, G&A, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330.

The intent of this regulation is to ensure the MCO has an ongoing quality assessment and PIP for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with SHCN.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of PSM's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual meetings held November 8, 2023. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- Chief Legal Counsel
- Quality Assurance Director
- Quality Assurance Specialist
- Compliance Officer
- Quality Manager, APS
- VP, Medical Affairs

Overall Assessment

Mercer found that PSM has comprehensive P&Ps and work plans to support its QAPI activities and oversight responsibilities. PSM illustrates a thorough, comprehensive process which describes the methodology used to monitor, analyze, evaluate, and improve the delivery, quality and appropriateness of healthcare offered to their beneficiaries and Enrollees, including those with special needs. PSM's QAPI program description includes the

approach to monitoring the availability, accessibility, continuity, and QOC and services on an ongoing basis. PSM maintains a structured, ongoing oversight process for QI and implements activities to monitor and improve. The Quality Committee meets on a quarterly basis to provide oversight to the Quality Improvement Program (QIP) by reviewing and approving quality activities and documents, such as the Quality Assessment and PIP Description, Work Plan, and Evaluation. The PSM Administrator has responsibility and authority of the Quality Committee which is ultimately overseen by PSM's Board of Directors.

Additionally, the submitted P&Ps provide a description of the process used by PSM's information systems to collect, integrate, analyze, and report data necessary to implement the QAPI. The UM Program evaluates overall utilization in the areas of Emergency Room, admission and readmission rates, coordination of services, over and underutilization, and evaluation of new technology. The 2022 PSM QAPI Program implemented over, under, and inappropriate utilization detection through its UM Program with the support of the QIP and have preventive services quality metrics in place, monitoring follow-up on admission and readmissions on a monthly basis to identify trends.

The PSM QAPI program descriptions and PIP work plans provide an overview of their approach to PIPs and activities. The policies illustrate approaches to achieve significant and sustainable health outcomes and the work plans provided specific information for the PRMP required PIPs: One clinical care project in the area of increasing fistula use for Enrollees at risk for dialysis; One clinical care project in the area of BH; One administrative project in the area of EPSDT screening; and One administrative project in the area of reverse co-location and co-location of PH and BH and their integration.

Lastly, PSM provided comprehensive PH and BH QAPI work plans outlining the roadmap for improving access, timeliness, outcomes, and quality. The work plans also illustrated the process for collection, analysis, and reporting and are designed to place focus on increasing screening, prevention, and appropriate care. Mercer was not able to locate language supporting PSM's process to ensure timely, complete, and accurate delivery of quarterly QIP reports.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO's PIP work plan and P&Ps support timely, complete, and accurate submission of a quarterly QIP Report. (42 C.F.R. § 438.330(d)(1)) (18.2.6.2) (Article 18)	Partially Met.	PSM provides a process for collection, analysis, and reporting data; however, there is not a P&P or SOP to evidence how PSM ensures timely, complete, and accurate delivery of quarterly QIP reports.	Develop a P&P that outlines how PSM ensures timely, complete, and accurate submission of quarterly QIP Reports.

Triple S GHP

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Triple S' organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual meetings held November 9, 2023. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- CEO
- COO
- VP, UM
- QI Medical Director
- Director, Credentialing
- Director, Finance
- Director, PI
- Director, Compliance Audit
- Director, Enrollee Services

Strengths

Triple S is represented by a strong and stable leadership team. The organizational culture demonstrates a commitment to serving Enrollees.

As a best practice, Triple S implemented requirements for reporting due dates to be tracked in a log for a designated compliance analyst to review and monitor daily. This allows for identifying upcoming reports to meet reporting requirements.

Triple S developed robust PowerBI dashboards used to assess monthly performance of overall inventory, paid and denied claims, as well as adjustments.

Opportunities for Improvement

Triple S offers useful Wellness Programs to Enrollees but does not have an established process to measure participation goals.

Triple S Member Services staff indicated that few complaints are sent to the G&A unit for investigation and there is a concern that doing so would result in negative feedback. There is an opportunity for Triple S to view member complaints and grievances as a process that is beneficial to continuous QI within the MCO versus viewing it as a failure in the system.

Triple S has the opportunity to enhance the PIP Aim Statements by clearly stating the improvement strategy, target population, measurable impact, and time period within each

PIP structures as well as demonstrate continuous QI techniques within the PIP evaluation process.

Recommendations

It is recommended Triple S develop a process to measure participation in wellness program and program effectiveness.

It is recommended that Triple S review its audit processes and determine appropriate sample size for audit of claims processed, paid, and denied. It is recommended that Triple S develop PIP Aim Statements that are clear, concise, measurable, and answerable, as well as adopt and implement continuous QI methodologies with the PIP process.

Administration and Organization

Overview

Organizational Structure

Triple S is a subsidiary of Triple S Management Corporation which offers commercial, federal, Medicaid, and Medicare Advantage lines of business in Puerto Rico. The GHP organizational structure falls under an Executive Affairs Administrator who reports directly to the CEO. This administrator oversees the General Manager of Medicaid, the COO, CMO, and the Strategic Initiatives Manager.

The COO oversees UM (including preauthorization and facility-based CM), health management, contracting and administration, service administration (including call centers), innovation and integration, and provider relationships and partnerships. The Chief Strategy Officer manages contracting and administration, clinic networks, provider relationships and partnerships, healthcare service and quality integration, and population health management. The CMO oversees medical quality, integrated delivery system, pharmacy, G&A, HEDIS and Stars, and the QI Medical Director.

Delegated Entities

Triple S delegates responsibilities to seven different entities outlined in the table below.

Delegated Entity	Type of Entity and Services
Abarca	Pharmacy benefit management (PBM).
APS Healthcare of Puerto Rico	MH — MH benefits, MH provider network credentialing and recredentialing, MH claims and processing and payment, pharmacy services, MH quality and UM services, behavioral healthcare management, MH and pharmacy G&A, MH education, reporting, MH Enrollee, and provider call center.
LinkActiv	Call center services for providers and beneficiaries and reporting.

Delegated Entity	Type of Entity and Services
Medical Advice Line	24-hour emergency medical advice toll free line.
Oncology Analytics (dba OncoHealth)	Oncology-related UM approvals.
Optum	Claims processing, IT.
Pager and Beeper Medical Group	Nursing advice line.
Telemedik	PSG call center for Medicaid Enrollees.

Triple S has P&Ps in place which operationalize the monitoring, oversight, and auditing of delegated entities. Oversight of delegated entities fall under Triple S' compliance and privacy officer.

Accreditation

Triple S did not report any accreditations during this report period. It is important to note that holding accreditations is not an existing contractual requirement.

Employee Training

Triple S requires all newly hired employees to complete a training curriculum through a Learning Management System which includes topics such as a review of Triple S' compliance program, advance directives, cultural competency, FWA, Elderly Financial Exploitation, Code of Business Conduct and Ethics, HIPAA, and a Medicaid overview. Customer services and G&A staff are required to also complete a training on G&A. Delegated entities must take trainings covering FWA, HIPAA, Code of Business Conduct and Ethics and a Medicaid overview, and UM delegated entities participate in IRR. All staff must complete these trainings annually thereafter. Triple S utilizes a variety of formats to train employees, including online trainings, in-person class trainings and written educational materials.

Enrollee Rights and Protections

A review of Enrollee rights and protections covered the following areas:

- Disenrollment requirements and limitations
- Enrollee rights requirements, including Enrollee rights and responsibilities, advance directives, the right to receive information, and moral and religious objections
- Information requirements for Enrollees

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MCO complies with the State enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MCO has written policies related to Enrollee rights and ensure the MCO complies and holds staff and affiliated providers accountable to comply with Enrollee rights and applicable State and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 438.10.

The intent of these regulations is to ensure the MCO provides appropriate information to Enrollees and potential Enrollees in a language and format that is easily understood. The MCO must inform Enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific Enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MCO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (j).

The intent of these regulations is to ensure the MCO maintains P&Ps related to advance directives, including their rights under State law, and must contain clear and concise language on the limitation if the MCO cannot implement an advance directive as a matter of conscience. The MCO is responsible for providing Enrollees with periodic written information regarding advance directives and their rights under the State laws. The MCO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MCO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MCO is responsible for ensuring enrollees have the right to participate in decisions regarding their care, to be free from any form of restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MCO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, and limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements for Enrollee rights and protections, Mercer conducted a thorough review of Triple S' Enrollee facing materials, employee training materials pertaining to Enrollee rights, associated P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through a virtual meeting held on November 9, 2023. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- Compliance Auditor
- Compliance Manager
- Brand Manager
- Enrollment Director
- Enrollment Manager
- Customer Service Director
- Nurse Care Manager

Overall Assessment

Disenrollment Requirements and Limitations

Triple S has a strong process in place to comply with CFR and contractual requirement pertaining to Enrollee disenrollments. P&Ps indicate that disenrollment occurs only when the Medicaid Program determines that an Enrollee is no longer eligible for the health plan, or when disenrollment is requested by the Contractor or Enrollee and approved by ASES. Triple S notifies Enrollees annually of their disenrollment rights and the plan utilizes an Enrollee disenrollment letter in which Enrollees are notified of the availability of the grievance system and ASES' ALH process when the request for disenrollment is initiated by the plan. The Enrollee handbook contains all requirements pertaining to disenrollment and associated Enrollee rights.

For voluntary disenrollments, Triple S' P&Ps show that Enrollees may request disenrollment from the MCO without cause once during the applicable Open Enrollment Period. These same P&Ps and the Enrollee handbook notify Enrollees of their grievance and administrative hearing rights and procedures, as they pertain to voluntary disenrollments.

Lastly, Triple S provided evidence that employees are trained on disenrollment processes and Enrollee rights pertaining to disenrollment.

Enrollee Rights Requirements

Regarding Enrollee rights, Triple S ensures all federal and Puerto Rico laws and regulations are adhered to and operationalizes these Enrollee rights in P&Ps and the Enrollee handbook. This includes Enrollee rights to request and receive their health information. Triple S also has a strong process in place to ensure all Enrollees are notified of their rights pertaining to advance directives and associated P&Ps address the requirement to reflect changes in the laws no later than 90 calendar days after the effective change.

Triple S does not currently have a process in place to guide providers and Enrollees when a provider issues a moral or religious objection to cover, reimburse, refer, or issue PA any service with the scope of the detailed covered services. Triple S will need to develop clear guidance to providers regarding notification requirements to the plan, ASES, and Enrollees when providers issue a moral or religious objection.

Information Requirements for Enrollees

Triple S adheres to CFR and contractual requirements pertaining to Enrollee information requirements and utilizes ASES' Universal Beneficiary Guide as a model that includes all contractual requirements for the Enrollee handbook. Triple S' P&Ps meet all requirements pertaining to the development and distribution of written materials in alternative formats and language based upon the needs of the Enrollee. There are clear procedures to develop/create, proof, submit and obtain ASES written approval, publish and/or mail the Enrollee ID card, Enrollee Handbook, Provider Directory, and form letters within contractual standards and timeframes.

Triple S also ensures that written Enrollee informational and instructional materials meet the language and format requirements outlined in contract standards. When written materials are requested in alternative formats, policies dictate that the generation of these materials take into consideration the Enrollee's special needs and Enrollees are informed on how to access those formats. Lastly, Triple S' policies indicate that Enrollees must be provided with at least 30 calendar days written notice of any significant change in policies concerning Enrollee rights, their right to change PMG or PCP, or any of the other items listed as Enrollee rights in the contract.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that describe the use of any moral or religious objections to cover, reimburse, refer, or PA any service with the scope of the detailed covered services. The P&Ps include notification to ASES, Enrollees and potential Enrollees as provided in 7.13.1 of the contract. (42 C.F.R. § 438.102(b) and 42 C.F.R. § 438.10(g)(2)(ii)(A and B)) The MCO has P&Ps that permit the Enrollee to change PCP due to moral or religious conflict. (5.4.1.5.1)	Not Met.	The plan did not provide any P&Ps or other evidence showing how the plan guides providers when they have a moral or religious objection or how providers should notify the plan, ASES and Enrollees of these objections.	Develop clear guidance to providers regarding notification requirements to the plan, ASES, and Enrollees when providers issue a moral or religious objection. Guidance may be within Provider Guidelines and/or associated P&Ps.

Provider Network — Access and Availability

A review of the provider network covered the following areas:

- Availability of services
- Furnishing of services and timely access

- Access and cultural considerations
- Assurances of adequate capacity and services
- Provider credentialing
- Sub-contractual relationships and delegation
- Practice guidelines

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MCO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MCO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MCO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MCO has written P&Ps for the selection and retention of providers and a documented process for the initial and recredentialing of providers. Regulation 438.214(c) and 438.12 (a–b) prohibits discrimination against

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the Triple S organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual meetings held November 9, 2023. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- Credentialing Director
- Provider Operations Director
- Vendor Management Contract Administrator
- Compliance Regulatory Lead
- Compliance Auditor

Overall Assessment

Triple S provided comprehensive documentation regarding their Medicaid service network. Mercer found most Plan Vital Contract and CFR requirements were documented in the

materials submitted for the desk review. Staff provided consistent responses during the virtual review and submitted the requested follow-up documents on time. The follow-up documents submitted provided evidence of contractual provisions in all but three areas.

Triple S presented with strong leadership and passion for their Enrollees. They have solid monitoring P&Ps to ensure network access is readily available for Enrollees. Triple S maintains a user-friendly online provider directory that covers provider capacity, cultural competency, handicap accessibility, languages spoken, affiliations, and hours of operation. They maintain P&Ps to keep the directory up to date. Through monitoring and reporting, Triple S ensures that the network has a sufficient array of providers, and that specialty providers can meet the needs of the expected number of Enrollees. When they identify barriers to access, they also identify alternative provider options and offer incentives.

Triple S provided evidence of coverage (EOC) for the required areas of women's health specialist for routine and preventive healthcare services, adequate and timely access, and coverage for Network Providers as well as OON services if Contractor is unable to provide such access. The policies submitted did not, however, cover the ability to obtain a second opinion, in- or- OON, at no cost to the Enrollee.

Triple S submitted the Provider Manual and Provider Guidelines that meet all of the contractually required criteria including but not limited to verifying eligibility, covered services, preferential turns, coordination of BH services, availability of medically necessary services 24 hours a day, reporting requirements, UM, medical record maintenance, complaints, G&A, co-payments, HIPAA, prohibition of denying medically necessary services, and sanctions or fines for non-compliance or FWA. Additionally, Triple S has a Participating Providers Relations Program that includes a provider orientation, with ongoing education and support provided virtually as well as in person.

Delegation agreements were submitted, verifying the oversight of delegated entities by the delegation department. The following table outlines the subcontractors that support Provider Network functions.

Delegated Entity	Delegated Services
APS Healthcare Puerto Rico	BH network management activities, including contracting and credentialing.
LinkActiv	Provider Call Center.
Therapy Network of Puerto Rico	Physical, Occupational, and Speech provider contracting and credentialing.

Triple S has a detailed credentialing and re-credentialing process as evidenced through the materials reviewed during the desk review and follow-up documents.

Triple S has a Provider Education Program, set up to promote compliance of clinical quality guidelines and standards and keeping providers up to date on best practices in managed care. The plan provides five hours quarterly for 20 hours total of continuing education annually.

Triple S provided a comprehensive Cultural Competency Plan as part of the follow-up documents. The plan lays out the requirements for providers to ensure Enrollees are treated without discrimination and that providers receive regular training on cultural competency areas. The plan does not clarify how and when it is distributed to providers or that it has been approved by ASES.

Provider Type	Number of Providers
PCP	1702
PMG	85
Hospital	52
Urgent care	13
Nursing facility	80
Dental	2
Vision	822
BH	106
FQHC	1020
Other	5983

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has established P&Ps on provider recruitment, retention and termination and describes how the MCO responds to changes in the network that affect access and availability of covered services. (9.1 & 9.3) Medicaid: (42 C.F.R. § 438.206) (42 CFR 438.207(c)) and CHIP: (42 C.F.R. § 457.1230(a)) (Attachment 2 and 20) (42 CFR 438.68) (Section 9.4) This includes women's health coverage, family planning, OON coverage and second opinions.	Partially Met.	The second opinion policy is not in line with CFR § 438.206 Availability of services as it does not state that it provides for a second opinion from a network provider or arranges for the Enrollee to obtain one outside the network, at no cost to the Enrollee.	Update provider contracts and P&Ps to align with CFR § 438.206, to show that second opinion coverage is offered at no cost to the member in- or- OON.
The MCO has a Cultural Competency plan that has been submitted to ASES and shared with providers that includes Information on how the Provider	Partially Met.	The Cultural Competency Plan does not state how it is distributed to providers. It is also unclear if this	Update the Cultural Competency Plan to show verification of ASES approval and how the plan is

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
may access the full Cultural Competency plan on the Contractor's website. This summary shall also detail how the Provider can request a hard copy from the Contractor at no charge to the Provider. (6.11) (10.3.1.29)		cultural competency plan has been approved by ASES.	distributed to providers.

Coordination and Continuity of Care

A review of the coordination and continuity of care covered the following areas:

- Identification of populations with SHCN
- Enrollee monitoring for medical conditions suggesting a need for care or disease management
- Protection of Enrollee records from unauthorized disclosure per the HIPAA Privacy and Security standards

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MCO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to Enrollees with SHCN, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care. The contractor shall develop and implement an integrated CC program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize QOC and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MCO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Triple S' organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual meetings held November 9, 2023. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- Compliance Auditor
- Audit Program Analyst
- Health Management Program Director
- Health Management Program Supervisor
- Health Management Program Manager
- VP, UM

Overall Assessment

Mercer found Triple S documentation provided evidence of compliance for some, but not all, of the regulatory or contractual provisions.

Triple S provided P&Ps illustrating details of the ongoing source of CM for Enrollees including but not limited to linking beneficiaries to services across providers including community and social supports, HRAs, gaps in care closure, interdisciplinary care team inclusion, care plan evaluation, and facilitation of coordinated services. Policy also included Population Identification Stratification Criteria describing criteria used to identify the level of CM engagement based on the Enrollee's PH and BH needs. Triple S CM processes included interventions to engage with Enrollees who are difficult to reach by contacting providers, pharmacies, facilities, or other provider types with recent claims to obtain updated Enrollee contact information and deploying outreach nurses to attempt face to face contacts. Triple S policy illustrated details regarding the coordination of care and support for discharge planning and transition into the community, including but not limited to support and weekly outreach during the first 30 days post discharge, follow-up appointment reminders and pre-authorizations, medication reconciliation, Enrollee education, and referrals as needed. The P&Ps also provided staff guidance for interventions to improve patient-provider communication, and how to coordinate services and continuity of care with members transitioning back into the community.

Triple S provided two Wellness Program Policies. The Prenatal and Maternal Health Education Program policy established procedures for coordinating educational activities aimed at preventing complications during and after pregnancy to ensure compliance with reaching 85% of women who receive services under the prenatal and wellness program. The Triple S overarching Wellness Program policy outlined procedures for coordination of educational activities, collaboration agreements, screenings, reporting through Triple S clinical platform, and monitoring compliance with the required education or training. Per the PRMP MCO contract, section 12.6.1.2.9, MCOs are required to "ensure that its Wellness Plan reaches, at a minimum, 85% of GHP Enrollees". Mercer was unable to locate language

describing the measurement strategy for reaching a minimum 85% of all GHP Enrollees in the Triple S Wellness Program policy.

Triple S provided a policy for its Clinical Integrated Care Unit (CICU) Enhanced Model illustrating the process to identify and offer CM services to Enrollees. The policy outlined the targeted populations for CM as individuals with SHCN, chronic conditions not covered under HCHN Program, SMI or Serious Emotional Disturbance diagnosis, high-cost or high-risk utilization, seven Emergency Department visits in 12 months, or high utilization. The policy also identified the additional criteria considered to perform stratification and distribution of the population. Additionally, the policy outlines direct referrals by other referral sources such as PCPs, Specialists, Admitting Physician Program, Teleconsulta/Tele MiSalud, Enrollees, family members/care givers, internal referrals, special coverage unit, BH Organizations, ASES or other governmental/external agencies.

Triple S also demonstrated several types of auditing it has implemented for CM. Supervisors are responsible for completing weekly monitoring for items such as HRA completion, timeliness of CM activities, Member admission monitoring and engagement, and CM interventions. If an area of opportunity is identified, the supervisor may develop a work plan with the care coordinator to improve their service provision. Triple S policy also illustrates the process for the CM team collaboration with the Quality Committee, as well as the requirements for timely, accurate, and comprehensive reporting using its regulatory compliance software program and the Health Plan Management System. As a best practice, Triple S implemented requirements for reporting due dates to be tracked in a log for a designated compliance analyst to review and monitor daily. This allows for identifying upcoming reports to meet reporting requirements.

The Triple S' Enrollee Handbook illustrates a high-level description of CM and how to contact the member service line, which is available seven days a week. Mercer was unable to identify language in the handbook explaining transition of care or how to access continued services pursuant to Triple S' transition of care process. Mercer was also unable to locate language in policy or the handbook describing the availability of healthcare services through Telehealth, Telemedicine, or Teledentistry. Triple S staff indicated during the virtual review they did not have a policy and procedure detailing the availability of Telehealth, Telemedicine, and Teledentistry services in place for the EQR period.

42 C.F.R. § 438.208(b)(4) requires that MCOs "share with the State or other MCOs, prepaid inpatient health plans (PIHPs), and PAHPs serving the Enrollee the results of any identification and assessment of that Enrollee's needs to prevent duplication of those activities." Triple S provided policy outlining the transition process when Beneficiaries transition from one carrier to Triple S, however Mercer is unable to identify language describing Triple S' responsibility to share information with PRMP or other MCOs to prevent duplication.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that provide: Details and support of an ongoing source of care for Enrollees appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee. The process for the MCO to provide information to the Enrollee on how to contact their designated person or entity. Coordination efforts P&Ps shall include consultation with Enrollee's PCP. Instructions to Enrollees and Potential Enrollees in the Enrollee Handbook and notices approved by ASES on how to access continued services pursuant to its transition of care process (42 C.F.R. § 438.208) (7.8.2.5) (7.8.2.4.6) (42 C.F.R. § 438.62) (6.1.8 Amendment A)	Partially Met.	Triple S provided a P&P for CICU Enhanced Model that provided details of the ongoing source of care for Enrollees. P&P also detailed coordination efforts with the Enrollee's PCP, process to share care plan with PCP. Triple S' Enrollee Handbook includes a high-level description of CM and how to contact, however, Mercer was unable to identify language explaining transition of care or how to access continued services pursuant to Triple S' transition of care process.	Revise the Enrollee Handbook and/or notices to include instructions to Enrollees and potential Enrollees on how to access continued services pursuant to Triple S' transition of care process.
The MCO has P&Ps on: Coordination of care that actively links the Enrollee to providers, medical services, residential, social, and other support services, including coordination of care between MCOs, settings of care and discharge planning for short and long-term hospital and institutional stays, and from community and social support providers. The availability of healthcare services through Telehealth, Telemedicine, and Teledentistry. (42 C.F.R. § 438.208(b)(2)) (7.8.2.3.7) (7.1.6 Amendment M)	Partially Met.	Triple S policy illustrates details regarding the coordination of care and support for discharge planning and transition into the community, including but not limited to support and weekly outreach during the first 30 days post discharge, follow-up appointments and pre-authorizations, medication reconciliation, member education, and referrals as needed.	Develop P&Ps on the availability of healthcare services through Telehealth, Telemedicine, and Teledentistry.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
		Triple S provided its Enrollee Handbook that outlines how an Enrollee can contact the Medical Advice Service Line or Vital call center, however Mercer was not able to locate language in policy or the handbook describing the availability of healthcare services through Telehealth, Telemedicine, or Teledentistry.	
The MCO's Wellness Plan includes: A strategy for coordination with government agencies of Puerto Rico integral to disease prevention efforts and education efforts, including the Health Department, the Department of the Family, and the Department of Education. The MCO's Wellness Plan incorporates strategies to reach all Enrollees including those living in remote areas of the Contractor's Service Regions. Measurement strategy for reaching at minimum, 85% of GHP Enrollees. Strategy to ensure 85% of pregnant Enrollees receive services under the Pre-Natal and Maternal Program. Strategies for encouraging Enrollees to: Seek annual healthy checkup; appropriately use the services of the GHP, including GHP Service line; Seek women's health screenings including mammograms, pap smears,	Partially Met.	Triple S provided two Wellness Program Policies. The Prenatal and Maternal Health Education Program policy established procedures for coordinating educational activities aimed at preventing complications during and after pregnancy and identified a goal of reaching 85% of women who receive services under the prenatal and wellness program. The Triple S overarching Wellness Program policy outlined procedures for coordination of educational activities, collaboration agreements, screenings, reporting through Triple S clinical platform, and follow-up procedures for the	Develop or revise policy to include strategies for reaching a minimum of 85% of all GHP Enrollees.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
cervical screenings, and test for sexually transmitted infections; Maintain a healthy body weight; seek an annual dental exam; Seek BH screening; Attend to the medical and developmental needs of children and adolescents; Receive education regarding the diagnosis and treatment of high-risk diagnosis including: Depression; Schizophrenia; Bipolar disorders; Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder; Substance abuse and Anxiety disorders. (7.5.8.2) (12.5.8.2) (12.6.1.2.1-9) (12.6.1.3)		compliance of the required education or training. Mercer was unable to locate language describing the measurement strategy for reaching a minimum 85% of all GHP Enrollees in the Triple S Wellness Program policy.	
The MCO has P&Ps that ensure: that information obtained through identification and assessment of Enrollee needs is shared with the state or other MCOs to prevent duplication, and that each provider maintains and shares Enrollee healthy records. Record sharing is in accordance with HIPAA Privacy and Security standards and as applicable during the care coordination process, all of the Enrollee's information is protected and kept confidential. (42 C.F.R. § 438.208(b)(4-6))(17.7) (17.11) 45 CFR Part 160, 164, subparts A, C and E.	Partially Met.	Triple S provided policy outlining the transition process when Beneficiaries transition from one carrier to Triple S, however Mercer is unable to identify language describing Triple S' responsibility to share information with PRMP or other MCOs to prevent duplication.	Revise or develop policy to ensure that information obtained through identification and assessment of Enrollee needs is shared with the state or other MCOs to prevent duplication, and that each provider maintains and shares Enrollee health records.

UM

A review of UM covered the following areas:

- Coverage and authorization of services
- Compensation for UM activities
- Emergency and post-stabilization services
- Timeframes for authorization decisions

- Prescription drug authorization requirements
- Adverse benefit determination

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MCO, with input from providers, has clinical practice guidelines in place that reflect the needs of Enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MCO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the Enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MCO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Triple S organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual meetings held November 9, 2023. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- Federal Compliance Officer
- SVP, UM
- UM Manager
- VP Pharmacy
- Pharmacy Manager
- UM Preauthorization Director
- UM Facility Based Director

Overall Assessment

The Triple S UM department provides prior authorization, on-site facility based concurrent review at 56 contracted facilities and a retrospective review of hospital admissions. The services requiring PA and concurrent review are clearly defined. UM decision making, timeframes and timeliness for specified services are well defined through the UM program

description and P&Ps. The UM program description is updated at least annually and is included in the QM evaluation.

Triple S has a UM committee that meets on a quarterly basis. The committee reviews the utilization activities, including any findings, and recommendations, the over and underutilization metrics, appeal and grievance data and referrals to CM and the Special Investigations unit (SIU).

Triple S reports that UM staffing is stable and all staff are dedicated to and reside within Puerto Rico. The PA unit teams are separate for Platino versus Vital members, while the on-site teams will service members in all lines of business. The on-site registered nurses support the transition process, coordinate with the social worker and make referrals to CM when indicated. The staffing model consists of clinical staff, called analysts, and non-clinical staff. All clinical decisions are evaluated by licensed clinical personnel and only physicians can make an adverse determination.

The Triple S supervisors monitor the caseloads and timelines of the PA unit at least three times a day. Admission reports are received daily and are used to assign staffing based on census at the 56 contracted facilities. Targeted quality case reviews are conducted as well as routine formal auditing for all team members.

Triple S and APS use InterQual as the evidence based clinical guidelines. National Comprehensive Cancer Network (NCCN) guidelines are utilized for oncology services. IRR is conducted at least annually via InterQual with a required passing rate of 85%.

Triple S utilizes two delegated entities as part of the UM operations. The compliance department is responsible for training and monitoring the performance through its Delegated Oversight Department.

APS is fully delegated to manage BH UM including prior authorization, clinical concurrent reviews, discharge planning, medical necessity review, physician consultation, and handling appeals. APS can access the Triple S system and provides monthly and quarterly reports as well as bi-weekly case discussions to coordinate care.

OncoHealth is delegated for PA approvals of chemotherapy and radiation protocols, PET scans, and genetic/molecular testing.

Triple S has a committee that meets on a quarterly basis to conduct an analysis of PH and MH services including a comparison of the services that require prior authorization, the process, denial rates, readmission rates and average lengths of stay. Triple S developed a policy for Compliance with MH Parity Law and performs a yearly comprehensive analysis to assess Non-Quantitative Treatment Limitations (NQTL) compliance for the program. The 2022 analysis did not identify any critical disparities between PH and MH.

MCO staff provided responses that were consistent with each other and the documentation in regard to providing written notice of adverse benefit determinations, that emergency and post stabilization services do not require a referral or prior authorization, and that staff are not incentivized for making UM decisions.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO has written P&Ps that reflect timeliness requirements applicable to PA decisions: (i) the MCO provides a decision no more than 72 hours from the time of the service authorization request for all covered services unless the MCO or Enrollee's provider determine that the Enrollee's life or health could be endangered by a delay in accessing services, in which case the decision must be provided as expeditiously as the Enrollee's health requires but no later than 24 hours from the service authorization request; (ii) the circumstances in which ASES may grant an extension of the decision timeframe for up to 14 calendar days (11.4.2.1.2); and requirement to provide the Enrollee with a written notice of the reason for the extension and right to file a grievance if the Enrollee disagrees with the decision. (11.4.2.1.3) (42 C.F.R. § 438.210(d)) Section 11.4.2	Partially Met.	The APS UM 01 policy does not indicate an expedited decision is within 24 hours.	Review, revise, and operationalize the APS policy to align with contractual and 42 CFR requirements.

G&A

A review of G&A covered the following areas:

- General grievance system requirements, including:
  - Information about the grievance systems shared with providers and subcontractors
  - Grievance system P&Ps
  - Authority to file
  - Handling of G&A
  - Recordkeeping requirements
- Grievance system management, including the grievance process and resolution and notification

- Appeals process management, including the appeals process and resolution and notification

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MCO has in effect a G&A system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MCO must inform members of how to access the grievance system, the availability of the MCO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MCO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MCO provides NOABD letters that are compliant with language, content, and format as required by Enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MCO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MCO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MCO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MCO must keep a log of all G&As filed. The MCO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Triple S' organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual meetings held November 9, 2023. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- Federal Compliance Officer
- QI Medical Director
- Supervisor, G&A
- Quality Analyst, G&A
- Manager, Customer Service
- Senior Analyst, Compliance

Overall Assessment

The grievance system follows standard processes. Complaints, grievances, and appeals can be received from members, member representatives, or providers verbally through Member Services, in person at a service center, or be written (i.e., filling out a form on the Triple S website and submitting it). Member G&A are managed in Virtual Appeal Manager (VAM), the MCO's system used to capture case file documentation and track progress for the investigation and resolution of all cases. VAM is also used to track compliance and create reports on G&A data. Member complaints are managed in Member Services in a different system. Triple S delegates MH member complaints, grievances, and appeals to APS who follows the same investigation and resolution process as the MCO, but in their own system. APS tracks all MH G&A and reports to their Quality Committee to identify trends and develop interventions and strategies. Triple S monitors APS' processes through quarterly audit reviews.

The Grievance Coordinator facilitates the grievance investigation, including coordinating investigations with other impacted business units. For example, the Provider Services Department will be sent quality of service grievances; QOC issues are investigated by the Clinical Management Division. Any information that is sent to or received from other units of Triple S during the investigation is documented in VAM. The 90-day timeline for resolving a grievance begins when the MCO receives the initial request (complaint or grievance). When a grievance is filed on behalf of the member, a signed authorization must be received before the MCO will begin investigation. If the MCO does not receive authorization within 15 days, the case is dismissed. Grievance data provides valuable information the MCO can use for continuous improvement. There is an opportunity for the MCO to conduct an informal investigation into all grievances. The G&A committee discusses trends monthly and reports to the Quality Committee and other business units.

Member complaints are received, documented, and resolved by Member Services within 72 hours of the initial call. If a complaint is not able to be resolved within 72 hours, it is referred to the G&A department for investigation and resolution. Complaints are categorized and

reviewed monthly by the Member Services department. During the virtual interview, Member Services staff indicated that few complaints are sent to the G&A unit for investigation and there is a concern that doing so would result in negative feedback. There is an opportunity for Triple S to view member complaints and grievances as beneficial to continuous QI within the MCO versus a failure in the system.

Similar to grievances, standard appeals are accepted both verbally (through Member Services) or in writing (appeals form can be found on the Triple S website and at Service Centers) and sent to Triple S via US mail, fax, or email. Verbal appeals filed by the member require a written appeal within 10 days of the verbal request.

Appeals staff are responsible for sending out member correspondence including the initial acknowledgement letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuity of care is requested in the appeal, the G&A analyst checks to ensure the proper steps have occurred and timelines are met. The member or member representative has an opportunity to present the case and answer any questions. The case is deliberated, and a decision is issued and communicated to the member verbally and in writing. For appeals that are overturned, the MCO authorizes services within 72 hours of the decision.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MCO's P&Ps, Enrollee Handbook, and Provider Manual clearly state that an Enrollee may file an appeal verbally or in writing within 60 Calendar Days after receiving an Adverse Benefit Determination and will acknowledge receipt of the appeal within 10 calendar days. (42 CFR §438.402 (2)(ii)) (14.3.3, 14.5.2, 14.5.4)	Partially Met.	P&Ps demonstrate that standard appeals can be filed by the member within 60 days after receiving an NOABD. The provider handbook and process flow chart have inconsistent timelines. Requirement for the member to confirm verbal appeals in writing does not align with federal regulations.	Review and update MCO P&Ps, the provider manual, and MCO process flow chart to align with the contract and federal regulations. Provide any necessary staff training, SOPs, or job aids related to changes made.
The MCO's P&Ps clearly state time frames for standard resolution of appeals and notification of the decision within 30 calendar days. (42 C.F.R. §438.408) Written Notice of Disposition of an appeal is provided to	Partially Met.	The G&A specialist enters the date an appeals decision was made into the system. However, it is not included in the member disposition letter template.	Update the member appeal disposition letter template to include the date the appeal was reviewed and decision made to align with 14.5.15 of the contract.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
the Enrollee within two Business Days of the decision. (14.5.9, 14.5.14 and 14.5.15)			

QAPI Program

A review of the QAPI program includes the following:

- The presence of an ongoing comprehensive QAPI program
- Monitoring and assessment of the QAPI
- Analysis and reporting of the QAPI
- PM
- PIPs

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, claims, G&A, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330.

The intent of this regulation is to ensure the MCO has an ongoing QAPI program for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with SHCN.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Triple S' organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual meetings held November 9, 2023. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- Federal Programs Supervisor
- Compliance Auditor
- QI Director

- QI Medical Director
- Service Management

Overall Assessment

Mercer found all required documentation provided evidence of compliance with regulatory or contractual provisions. During the virtual review, Mercer also observed Triple S staff provided responses that were consistent with each other and with the submitted documentation.

The Mercer assessment further found that Triple S has comprehensive P&Ps and work plans to support its QAPI activities and oversight responsibilities. Triple S illustrates a thorough, comprehensive process to describe the methodology used to monitor, analyze, evaluate, and improve the delivery, quality and appropriateness of healthcare offered to their beneficiaries and Enrollees, including those with special needs. The QAPI program outlines the organizational structure, committees and meeting schedules, description of clinical quality audits, surveys, PIPs, and quality initiatives and describes how Triple S facilitates both member and provider advisory committees at least twice a year.

Additionally, the UM Program description provides an overview of QI collaboration, program reporting, stakeholders and activities, and staff involvement in committees on a quarterly basis as well as the responsibility of the Quality Council for monitoring of over/under utilization. The IT Department's P&Ps outline how the department oversees the systems and applications addressing collection, maintenance, and analysis of information as well as adherence to protected health information. Monitoring and reviewing of data are performed on a quarterly basis and include evaluating the need for interventions to improve performance and/or address barriers.

Lastly, Triple S, through its QAPI Program, has established a PIP work plan, with a process for PIP development and methodology used for evaluation to determine performance and improvement. Triple S' process includes a description of its approach for oversight and monitoring, including reporting and data collection, with the Quality Improvement Department responsible for the oversight of the PIPs as well as presenting the results to the QI committee at least three times a year. Triple S' work plan outlines measurable objectives, action steps, cadence for meeting and reporting, and responsible parties for various quality issues related to these performance activities.

Findings

Triple S met all requirements for these metrics through RFI documents, on-site discussions, and post on-site submissions.

Appendix B

Review of Compliance with Medicaid Managed Care Regulations for Platino Health Plans

Introduction

To complete the review of compliance with Medicaid managed care regulations, Mercer utilized the mandatory compliance validation protocol (Protocol 3) to determine the extent to which MAOs comply with federal standards set forth in 42 CFR 438, part 56, 100, 114, Subparts D and QAPI, state standards, and MAO contract requirements. Below is a crosswalk of the standards reviewed by the EQRO.

Standard Reviewed by the EQRO	CFR Part 438
Enrollee Rights and Protections	§438.56 Disenrollment requirements and limitations
	§438.100 Enrollee rights requirements
Access and Availability	§438.206 Availability of Services
	§438.207 Assurances of Adequate Capacity of Services
Care Management	§438.208 Coordination and Continuity of Care §438.224 Confidentiality
Utilization Management (UM)	§438.210 Coverage and Authorization of Services
	§438.114 Emergency and post-stabilization services §438.236 Practice Guidelines
Provider Network	§438.214 Provider Selection
	§438.230 Sub-contractual Relationships and Delegation
Grievance and Appeals (G&A)	§438.228 Grievance and Appeal Systems
Quality Improvement and Assessment	§438.242 Health Information Systems
	§438.330 QAPI

Humana

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Humana's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 23, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- CEO/President
- VPs
- Directors
- Associate Directors
- Senior Officers
- Supervisors
- Area Leads
- Project Managers
- Advisors
- Officers

Strengths

Humana's team showed engagement and willingness to participate in on-site discussions which provided additional detail to abiding by the Code of Federal Regulations and the Platino contract.

Humana has an established UM program with experienced personnel. The UM department is structured by function but staff are cross trained, allowing for coverage or reallocation of resources to manage the need. Humana has strong delegated oversight of the UM department.

Opportunities for Improvement

While Humana reports procedures that are in alignment with 42 CFR and the Platino contract, there is the need to review and revise or develop P&Ps to ensure that all federal and contractual requirements are followed.

Enrollee complaints are documented and tracked by Customer Service through a customer relationship management system. It is unclear whether complaints are tracked and trends identified.

Recommendations

Review and revise available P&Ps to ensure regulatory and contractual compliance. Provide training to staff on new developed and revised P&Ps.

The MAO should explore to create an integrated grievance, complaints, and appeals system that maximizes the use of grievance and complaints data for continuous QI.

Administration and Organization

Overview

Organizational Structure

Humana Platino organizational structure includes a corporate board of directors which provides oversight of Humana's executive leadership team. The President and CEO oversees the Regional VP of Operations who, in turn, oversees Service Operations. Service Operations includes key departments serving Humana Platino Enrollees including the Quality Department (including the Audits Division and the call center), Claims Processing (including provider contracting, credentialing, and recredentialing), Consumer Service Operations (including Enrollee enrollment, G&A, and Enrollee service centers) and Business Support Coordination (providing general administrative support to the organization). Clinical Operations is led by the Regional VP of Health Services/CMO and includes UM, quality management, clinical programs, pharmacy, and CM. Humana offers both Platino and Commercial lines of business in Puerto Rico and their approach to staffing includes cross-training to other lines of business and markets.

Delegated entities

Humana Platino delegates responsibilities to eight different entities outlined in the table below.

Delegated Entity	Type of Entity and Services
APS Healthcare of Puerto Rico	MH Services — MH benefits, MH provider network credentialing and recredentialing, MH claims processing and payment, pharmacy services, MH quality and UM services, BH CM, MH and pharmacy G&A, MH education, reporting, and MH Enrollee and provider call center.
Argus Dental and Vision	Vision Services — claims adjudication, credentialing, and re-credentialing.
Inovio	Network Services — credentialing and re-credentialing services.
Luxottica of America (dba EyeMed Vision Care)	Vision Services — claims adjudication for routine vision services.

Delegated Entity	Type of Entity and Services
Net Claims Solution	Dental Services — claims processing, direct Enrollees reimbursements, and dental preservice platform.
Oncology Analytics (dba OncoHealth)	Oncology-Related UM Approvals.
Telecontacto	Call Center Services — auditing of data submitted by Operational Risk Management to review compliance with CMS, state, and Medicaid requirements.
Therapy Network of Puerto Rico (TNPR) — also known as Health Network One (HN1)	Physical, Occupational, and Speech Therapy — contracting, credentialing, and re-credentialing of providers, providers call center, pre-service organization determinations, and claims processing.

Humana has P&Ps in place operationalizing the auditing, oversight, and monitoring of delegated polices. These policies describe audit and corrective action procedures, protection of PHI and requirements pertaining to sub delegation.

Accreditation

Accreditation is not a contract requirement. No accreditations were submitted by Humana for this timeframe.

Employee Training

All Humana Platino associates, contractors, delegates, and sub-delegates are required to receive training on cultural competency, FWA, and HIPAA. Call center staff are trained on G&A and a variety of staff are trained on advance directives. Additional training for new associates is determined by the hiring leader based on the needs of the department and/or position. Humana Platino reports that all vendors must complete the Humana Privacy and Humana Ethics training annually, as provided by Humana.

Enrollee Rights and Protections

A review of Enrollee rights and protections covered the following areas:

- Disenrollment requirements and limitations
- Enrollee rights requirements, including Enrollee rights and responsibilities, advance directives, the right to receive information, and moral and religious objections
- Information requirements for Enrollees

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MAO complies with the State enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MAO has written policies related to Enrollee rights and ensure the MAO complies and holds staff and affiliated providers accountable to comply with Enrollee rights and applicable State and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 438.10.

The intent of these regulations is to ensure the MAO provides appropriate information to Enrollees and potential Enrollees in a language and format that is easily understood. The MAO must inform Enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific Enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MAO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (j).

The intent of these regulations is to ensure the MAO maintains P&Ps related to advance directives, including their rights under State law, and must contain clear and concise language on the limitation if the MAO cannot implement an advance directive as a matter of conscience. The MAO is responsible for providing Enrollees with periodic written information regarding advance directives and their rights under the State laws. The MAO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: , 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MAO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MAO is responsible for ensuring enrollees have the right to participate in decisions regarding their care, to be free from any from or restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MAO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate Humana's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Humana's RFI response, consisting of policies, procedures, processes, workflows, and supporting documentation, including the Enrollee Handbook, Enrollee materials, contract templates, reports, letter templates, staff handbooks, training material, training schedules, and Humana's Enrollee website. This review was conducted based on information submitted by Humana through the RFI and through on-site meetings held October 23, 2023. The on-site meetings involved key leadership from the MAO including, but not limited to:

- Operations VP
- Senior Compliance Professional
- Risk Management Lead
- Compliance Associate Directors
- Lead Product Manager

Overall Assessment

Disenrollment Requirements and Limitations

Humana has a strong process in place to ensure the plan is compliant with all CFR and contractual requirements pertaining to Enrollee disenrollments. There are clear written P&Ps for processing both voluntary and involuntary disenrollment requests in accordance with the enrollment and disenrollment guidance from the Medicare Managed Care Manual. Disenrollment information for Enrollees and their rights pertaining to disenrollment (including G&A rights) can be found in the EOC and Annual Notice of Change (ANOC) and within disenrollment letters sent to Enrollees. Humana also sends disenrollment letters to Enrollees depending on their specific circumstance. Examples of disenrollment letters include confirmation of request to disenroll, confirmation of disenrollment from Medicare Advantage Plan, change in Medicaid eligibility, and when the Enrollee plan ends.

Humana has P&Ps in place which reflect that disenrollment occurs only as directed by ASES. Enrollees, per contract and federal regulations, are notified annually of their disenrollment rights. Notification indicates the process for exercising this right, as well as alternatives available to the Enrollee based on their specific circumstance. Humana has procedures in place to ensure Enrollees are not disenrolled without the Enrollees' consent. Humana also has processes in place to communicate disenrollment complaints to ASES.

Enrollee Rights Requirements

Humana has a strong process in place to ensure compliance with all federal and Puerto Rico laws pertaining to Enrollee rights. This includes having P&Ps in place outlining all Enrollee rights, publishing of these in the Summary of Benefits and Value Added Items and Services (New Enrollee Packet), the EOC, and the ANOC. Enrollees are advised of their rights and responsibilities upon enrollment and annually thereafter. Enrollees may request and receive a copy of their medical records and request to amend or correct their medical record as required by federal regulations.

Humana's Enrollee Rights and Protections policy outlines obligations related to Enrollee's rights and protections including non-discrimination provisions. Complaints, escalation of complaints, and grievance procedures, as well as the right to refuse medical treatment are noted in the policy. Humana meets the federal regulation and contract requirements for notification of Enrollees regarding their rights to formulate advance directives. Humana educates their Enrollees on how to exercise this right in the Enrollee Handbook upon enrollment and annually. Customer Care Specialists receive training on how to guide Enrollees and prospective Enrollees who may call inquiring about advance directives. There

is a dedicated 1-hour training for senior awareness focusing on advance directives. Humana also educates Enrollees regarding advance directives throughout the CM Program.

Humana does not have a policy or procedure outlining the process for moral and religious objections. Contract requirements and federal regulations requires that providers who elect not to provide, not to reimburse, or not to provide a referral or PA for a service within the scope of the detailed covered service, must notify ASES and Enrollees within a required timeframe. Although Humana expects subcontractors to ensure they can provide and deliver all specified services before engaging in a business relationship, there is not a formalized policy addressing how Humana responds when a subcontractor refuses service on moral or religious grounds. Humana lacks a policy outlining the process to inform the Enrollee and ASES, including timelines for notification, as well as how such circumstances are managed throughout the process.

Information Requirements for Enrollees

Humana fully complies with all CFR and contractual requirements pertaining to information requirements for Enrollees. Once a prospective Enrollee decides to enroll in the plan, an enrollment is completed using an electronic or paper application. An agent will complete and submit the application once all information is gathered. All new Enrollees receive an affiliation receipt, summary of benefits, EOC, annual notification of changes, Provider Directory, CMS star rating, and additional/extra benefits. Once enrolled, Enrollees are sent a welcome kit and letter, plan ID card, Humana extra or flex allowance card (if applicable), and other supporting documentation.

Humana ensures all informational and instructional materials for Enrollees and potential Enrollees communicate in a manner and format that is easily understood. Humana has P&Ps in place consistent with contract requirements and federal regulations for written materials, including alternate formats for special needs such as visual impairment or limited reading proficiency. Humana’s documents are mostly model documents following CMS models/guidelines. Enrollees are informed of these rights and receive instructions on how to access alternative options in the EOC booklet and the Summary of Benefits and Value-Added Items and Services handbook.

Enrollees are required to be notified of any important changes in the Enrollee Handbook, Provider Directory, or other documents. To maintain consistency and avoid disruptions, significant alterations are typically avoided during the enrollment year. Impact analyses are conducted and, if changes are pertinent and inevitable, Enrollees are informed 30 days in advance.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has P&Ps in place to ensure: (5.5.1-5.5.3) If, during the course of the Contract period, pursuant to 42 CFR 438.102, the Contractor elects not to provide, not to reimburse for, or not to	Not Met	P&Ps including processes for moral and religious objections for	Develop P&Ps outlining process for moral and

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
provide a Referral or PA for a service within the scope of the detailed Covered Services, because of an objection on moral or religious grounds, the Contractor shall notify ASES within 120 calendar days before adopting the policy with respect to any service; Enrollees within 90 calendar days after adopting the policy with respect to any service; and Enrollees before and during Enrollment. The Contractor shall furnish information about the services it does not cover based on a moral or religious objection to ASES.		this metric were not submitted pre or post on-site review.	religious objections.

Provider Network — Access and Availability

A review of the provider network covered the following areas:

- Availability of services
- Furnishing of services and timely access
- Access and cultural considerations
- Assurances of adequate capacity and services
- Provider credentialing
- Sub-contractual relationships and delegation
- Practice guidelines

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MAO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MAO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MAO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MAO has written P&Ps for the selection and retention of providers and a documented process for the initial and recredentialing of providers. Regulation 438.214(c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214(d) prohibits the MAO from contracting with providers that are excluded from participation in Medicare and State healthcare programs.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with State requirements. The MAO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network (OON).

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MAO has P&Ps in place which guarantee the MAO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MAO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The intent of these regulations is to ensure the MAO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MAO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers, and financial considerations.

The following federal regulation is addressed in this section: 438.104.

The intent of this regulation is to ensure the MAO obtains State approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Humana's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through an on-site meeting held on October 23, 2023. The on-site meeting involved participation from MAO key leadership including, but not limited to:

- Provider Engagement Director
- Claims Associate Director
- Provider Engagement Manager
- VP, Operations

- Associate Director, Compliance

Overall Assessment

Humana's comprehensive documentation provided evidence of processes in place to meet Medicaid wrap-around service network requirements for Enrollees as required through the Platino Contract and CFR requirements. The Network Management Program Description (NMPD) includes the program objective and goals, health services which describes provider service types, and a description of the population. Detailed documentation is included for the following topic areas:

- Network accessibility and availability
- Provider selection criteria
- Provider communications (new provider orientation, provider updates, and provider websites)
- Provider representation
- Provider violations and dispute resolution

The Provider Manual is comprehensive and user friendly. There are examples with screen shots to assist providers with processes. It includes required information describing the Medicaid wrap-around services including OON coverage and information for Enrollee access to a women's health specialist. The language in the EOC indicates that the MAO is responsible for ensuring Enrollees are informed about family planning options, including the implications of voluntary sterilization for men and women of legal age and sound mind. CFR § 438.206 requires, through availability of services, a second opinion is available at no cost to the Enrollee. The information provided in the EOC regarding second opinion indicates that Enrollees are entitled to seek second opinion from another network provider before undergoing surgery. Neither the Provider Manual, nor the EOC provides a description for Enrollees and providers to seek second opinions outside of those prior to a surgical procedure. The Platino contract requires specific provider guidelines to be distributed to providers within 15 calendar days of contracting with the MAO. Inclusion of all the contractual elements required for provider guidelines as well as the process to distribute the document within 15 calendar days of contracting is needed to complete the contractual requirement.

Humana's Provider Directory includes contractual fields (e.g., NPI, name, address, phone number, e-mail, provider category [including pharmacy and BH providers], specialty description, a notation if the provider is accepting new patients, group designation, office hours, website, cultural and linguistic capabilities, and accommodations for people with physical disabilities). Changes are made within one calendar day of receiving the provider information. The on-line directory allows the user to search by: gender, language spoken, accessibility, hospital privileges, or accreditation and certifications and the ability to download search results to either Excel or pdf if desired. The Humana Provider Directory does not include the requirement for provider completion of Cultural Competency training. As a follow-up, Humana will implement an indicator on the Providers Directory when a provider completed the Cultural Competency training.

Humana's NMPD includes the process in place to develop and continually assess provider network needs using two access measures and two availability measures.

Access Measures	Availability Measures
Provider to Enrollee ratios	Maximum wait times for appointments.
Geo-access mapping for time and distance to practitioner locations	Rate of Enrollee use of In Network versus OON providers .

The Quality Management Committee (QMC) provides oversight of network access and availability by routinely reviewing the various reports indicated above. Additionally, the NMPD is evaluated against its program objectives and goals annually. This evaluation is included in the QM Program Evaluation Report and reviewed by the QMC.

Humana delegates provider network services as outlined in the table below.

Delegated Entity	Type of Entity and Services
APS Healthcare Puerto Rico	BH network management activities, including contracting and credentialing services.
Argus Dental and Vision	Credentialing and re-credentialing services.
Inovalon, Inc.	Credentialing and re-credentialing services.
TNPR	Physical, Occupational, and Speech provider contracting and credentialing.

Oversight and monitoring for delegated entities is outlined within the delegation policy outlines and led by the compliance department. There is a specific audit tool used to monitor contracting and credentialing which takes place on an annual basis. Humana submitted the 2022 oversight audits and summaries. For credentialing, the overall 2022 scoring was as follows: APS: 100%, Argus: 99.1%, Inovalon: 100%, and TNPR: 100%.

The Humana Credentialing Puerto Rico Internal Policy indicates that providers are required to have a certification of enrollment in the PRMP. The medical practice facility evaluation form is used by Humana to assess various aspects of healthcare facilities and ensures that healthcare facilities meet specific standards of care, safety, and accessibility. The evaluation categories include physical facilities, accessibility and availability, medical records, availability of appointments, OSHA and work safety, and other factors. The scoring system assigns different point values to each category, with a total of 42 points for physician providers and 23 for allied providers. A score of 30–42 points for physicians and 19–23 points for allied providers is considered satisfactory, while lower scores are deemed unsatisfactory. Humana provided an example of a completed medical practice facility evaluation form, which was completed on October 17, 2023. In this instance, the evaluated practice received a total score of 35 points, categorizing it as satisfactory according to

Humana's scoring criteria. This example demonstrates the practical application of the evaluation form and the standards necessary for a practice to achieve a satisfactory rating.

As documented in the NMPD, Humana implements a participating Provider Relations Program to ensure providers receive necessary information and communication. Humana ensures providers have access to all statutes, rules, regulations, guidelines, policies, operational procedures, and recommendations necessary to fulfill their obligations as providers. Processes for provider updates and information are in place to be available on the Humana website. All Humana associates and contractors are required to complete:

- Advance Directives
- Cultural Competency
- FWA
- HIPAA, Privacy, and Confidentiality

The following trainings are listed but not stating that all Humana Associates and Contractors are trained on these:

- BH
- Enrollee Rights
- G&A
- Medicaid Overview, including Covered Services
- Any Other Additional Trainings

Humana submitted a comprehensive Cultural Competency Training for Healthcare Providers. The training reflects a proactive approach to ensuring inclusive and sensitive indicators for healthcare services. The training includes topics such as culture and cultural competency, clear communication, subcultures and populations, and strategies to work with seniors and people with disabilities. The training informs providers that the cultural competency plan and training are available through the compliance department.

Number of Humana Platino Contracted Providers in 2022:

Provider Type	Number of Provider Types in 2022
PCP	3,451
PMGs	10
Hospital	55
Urgent care	23
Nursing facility	4
Dental	576
Vision	394
BH	960
FQHC	4

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has P&P in place aligning with:(42 C.F.R. § 438.206) (42 CFR 438.207(c)) (6.1.1- 6.1.2) establish and maintain a network of Network Providers that complies with 42 CFR 438.206(b)(l) and is otherwise sufficient to provide adequate access to covered services to meet the needs of Enrollees in the Medicare Platino Plan. This must include a women's health specialist to provide women's routine and preventive healthcare services, Ability to obtain a second opinion, in-or- OON, at no cost to the Enrollee. Adequate and timely access and coverage for Network Providers as well as OON services if Contractor is unable to provide such access.	Partially Met	The information provided in the EOC regarding second opinion indicates that Enrollees are entitled to seek second opinion from another network provider before undergoing surgery. The development of these P&Ps will ensure Enrollees make well-informed healthcare decisions and improve treatment outcome.	Develop an expanded P&P that allows Enrollees to seek second opinion for a broader range of medical services, besides surgical procedures. Provide the process to communicate this update to providers and Enrollees.
The MAO has P&P in place and a (4.3.1.1-4.2.1.2) Provider Directory with the names of physicians, including specialists, hospitals, pharmacies, BH providers, covered under this Contract, along with their provider group affiliations, locations, office hours, telephone numbers, websites, cultural and linguistic capabilities, completion of Cultural Competency training, and accommodations for people with physical disabilities of	Partially Met	The Provider Directory does not appear to include completion of Cultural Competency training as required by 4.3.1.1.	Add an indicator to the Provider Directory showing that a provider has completed Cultural Competency training.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
current Network Providers. The Provider Directory shall also identify all Network Providers that are not accepting new patients.			
The MAO has Provider Guidelines in place and P&P to ensure: (7.1.1-7.1.6) The Contractor shall prepare Provider Guidelines, to be distributed to all Network Providers. The Provider Guidelines shall, in accordance with 42 CFR 438.236, (i) be based on valid and reliable clinical evidence or a consensus of Providers in the particular field; (ii) consider the needs of the Contractor's Enrollees; (iii) be adopted in consultation with Providers; and (iv) be reviewed and updated periodically, as appropriate.	Partially Met	The Humana Provider Manual offers comprehensive information aligning for most of the contractual Provider Guideline requirements, there are areas that are not included: Electronic Health Records and sanctions or fines applicable in cases of non-compliance, and FWA compliance. Evidence of delivering the Provider Guidelines to providers within 15 days of contracting. Report requirements. UM P&Ps. Medical Record maintenance requirements.	Update the Provider Manual to include all contractual elements required for Provider Guidelines as well as the process to distribute the document within 15 calendar days of contracting is needed to complete the contractual requirement.

Coordination and Continuity of Care

A review of the coordination and continuity of care covered the following areas:

- Identification of populations with SHCN
- Enrollee monitoring for medical conditions suggesting a need for care or disease management
- Protection of Enrollee records from unauthorized disclosure per the HIPAA Privacy and Security standards

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MAO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to Enrollees with SHCN, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated CC program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize QOC and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MAO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Humana's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 23, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- CMO
- Health Services Director
- Compliance Officer

Overall Assessment

Mercer found all required documentation provided evidence of compliance with regulatory or contractual provisions. During the on-site review, Mercer observed Humana staff provided additional material and documents, further demonstrating and confirming their compliance.

The on-site review supported Humana's RFI response and deliverables, observing staff's ability to demonstrate their knowledge and understanding of the P&Ps in place outlining their efforts to engage eligible Enrollees in the care coordination program and timeframe requirements for a HRA completion. Additionally, Humana demonstrated evidence of processes in place that ensure consistent risk stratification, as well as processes to detect if re-stratification is needed. The MAO confirmed its process includes an established service

intensity, based on the level of risk stratification, with specific contact requirements. Humana demonstrated its ability to receive referrals from multiple sources, and there are procedures for coordinating with Enrollees being discharged from the hospital to prevent rehospitalization. Lastly, Humana confirmed its process for the identified five conditions that would immediately qualify an Enrollee for care coordination.

Findings

Humana met all requirements for these metrics through RFI documents, on-site discussions, and post on-site submissions.

UM

A review of UM covered the following areas:

- Coverage and authorization of services
- Compensation for UM activities
- Emergency and post-stabilization services
- Timeframes for authorization decisions
- Prescription drug authorization requirements
- Adverse benefit determination

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MAO, with input from providers, has clinical practice guidelines in place that reflect the needs of Enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MAO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the Enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MAO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MAO’s compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Humana’s organizational charts, training materials,

P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through an on-site meeting held on October 23, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- VP, Clinical Operations
- UM Director
- Senior Compliance Officer
- Senior Performance Officer
- Associate Director

Overall Assessment

The UM department provides prior authorization, concurrent and retrospective review. UM decision making, timeframes, and timeliness are well defined through the UM program description and P&Ps. The UM program description is updated at least annually and is included in the QM evaluation and presented to the QIC and Corporate Quality Improvement Committee (CQIC).

UM staffing is based on membership, case rates, and caseloads. The department is structured to include one team for PA and one team for concurrent/retrospective review. The teams include registered nurses, a social worker, and non-clinical staff. Teams are fully dedicated to Puerto Rico and all but three live in Puerto Rico. All clinical staff and peer reviewers are licensed in Puerto Rico. Clinical consult is available with a supervisor or physician. A comprehensive training plan is in place for UM to address the requirements of the P&Ps and support staff in performing job duties. IRR is conducted annually. UM supervisors conduct targeted audits and quality conducts additional audits.

Humana utilizes Interqual, CMS, and local coverage determinations and specialty societies such as American College of cardiology and radiology. Interqual is embedded into the clinical system and other criteria sets are accessed through links in the system. Clinical guidelines are evaluated by the Puerto Rico Peer Review Committee (PRC) and approved by the CMO at least annually.

UM leadership tracks and trends the different service categories to monitor performance. Humana UM staff has not established any utilization thresholds as they report the extreme variations from the COVID-19 PHE and Hurricane Maria did not allow for any stable utilization for comparison.

Humana has a specific delegation policy in place and all delegated vendors complete Humana trainings including privacy and ethics, IRR, and others annually. Humana conducts annual delegation compliance audits of the UM program including policy review, program documents, and file audits. There are three delegated arrangements that perform UM functions. The first is APS, which manages the BH UM including prior authorization for partial hospital and electroconvulsive therapy (ECT), concurrent review and retrospective review. Grievances and appeals are managed by Humana. Humana and APS conduct monthly case discussions to review cases and coordinate care. The clinical platform allows Humana to

view a BH clinical summary and BH/SUD claims. APS utilizes Medicare Milliman Clinical Guidelines, CMS, and diagnostically based clinical guidelines. The APS Delegation Services Addendum clearly outlines the delegated functions. The APS UM audit resulted in a score of 100% for the UM program, P&P, work plan, authorization and referral files, standard denial files, and provider termination files.

The second is OncoHealth which is responsible for pre-service consultation of oncology services and denial recommendations. Humana submitted the participation agreement between Oncology Analytics and Humana; however, the effective date of the agreement was listed as “TBD”. The OncoHealth delegation compliance audit resulted in scores of 100% for the UM program, P&Ps, work plan, authorization and referral files and denial recommendations. The review of timeliness standards scored 99%. Lastly, TNPR is responsible for UM approvals of therapy services. The UM policy and file review audit resulted in a score of 100%.

Humana and APS review their services subject to UM and compare policies to ensure requirements are comparable and not more stringent for BH services.

Mercer found all required documentation was present and MAO staff provided responses that were consistent with each other and the documentation regarding the timeframe for PA decisions and providing written NOABD.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has written P&Ps that: (i) identify, define, and specify the amount, duration, and scope of covered services available under the contract and how and where to access such services; (42 C.F.R. § 438.10. Platino section 4.3.1.2). The MAO has P&Ps to ensure its PA requirements comply with the requirements for parity in MH and SUD benefits under 42 C.F.R.§ 438.910(d) (Platino 5.3.9.2).	Partially met	Humana provides a summary of benefits and EOC to Enrollees which outlines coverage services and how to access care. The Policy Enrollee Rights and Protections includes this information. Humana described a process by which they review UM P&P with APS to analyze for non-quantitative treatment limitations, but no written policy was submitted.	Develop P&P that outline the MAO’s process to ensure authorization requirements comply with parity requirements.
The MAO has written UM P&Ps to assist Enrollees and providers to ensure appropriate utilization of resources. The MAO's P&Ps	Partially Met	Humana has P&Ps that clearly define the process of authorization of services.	Develop P&P for UM staff that outlines a plan to define, detect, monitor, and intervene

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
reflect the subcomponents listed under 8.2.1 of the Platino contract (42 C.F.R. § 438.210(a)(3 and 4) and 42 C.F.R. § 438.210(b)).		Humana described a process of monitoring utilization which did not include a current strategy for detecting over/under utilization.	for over/under utilization.
The MAO has written P&Ps that prohibit the MAO or any delegated UM agent from providing compensation or anything of value to its employees, agents, or contractors based on: either a percentage of the amount by which a claim is reduced for the payment or the number of claims or the cost of services for the denied authorization or payment; or any other method that encourages a decision to deny, limit, or discontinue a Medically Necessary covered service to any Enrollee (Platino 8.2.4) (42 C.F.R. § 438.210(e)).	Partially Met	Humana reported that the ethics and compliance training includes this expectation, and while the training included a section on receiving and accepting gifts, it was not specific to UM decisions. The UM program description includes this language but a written P&P was not submitted. The TNPR and APS delegation agreements include language that the delegate will not provide incentives to approve, limit, or discontinue medical necessity services. The OncoHealth participation agreement did not include the language and the effective date of this agreement is marked as “TBD”.	Develop Humana P&Ps that prohibits the MAO or any delegated UM agent from incentivizing UM decisions. Develop a dated OncoHealth agreement that includes language prohibiting providing incentives for UM decisions.
The MAO has written P&Ps that reflect that: (i) emergency services do not require a referral or prior authorization, (ii) the MAO covers post-stabilization services consistent with the requirements in 5.3 of the contract; and (iii) the Enrollee treated for an	Partially Met	Humana provided a policy HGO UM 132 Emergency Services V5 that includes language that emergency services do not require preauthorization or prior authorization. No policy was found that included language	Develop P&P that reflects that post stabilization services are covered and that the Enrollee is not liable for any post stabilization treatment.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
emergency medical condition or psychiatric emergency shall not be held liable for any subsequent screening or treatment necessary to stabilize the Enrollee (42 C.F.R. § 438.114) (Platino 8.6; 5.3).		related to the coverage of post stabilization treatment.	

G&A

A review of G&A covered the following areas:

- General grievance system requirements, including:
  - Information about the grievance systems shared with providers and subcontractors
  - Grievance system P&Ps
  - Authority to file
  - Handling of G&A
  - Recordkeeping requirements
- Grievance system management, including the grievance process and resolution, and notification
- Appeals process management, including the appeals process, resolution, and notification

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MAO has in effect a grievance and appeal system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MAO must inform members of how to access the grievance system, the availability of the MAO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MAO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MAO provides NOABD letters that are compliant with language, content, and format as required by Enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MAO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MAO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MAO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MAO must keep a log of all G&As filed. The MAO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate Humana's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Humana's RFI response and supporting documentation including P&Ps, Enrollee Handbook, Humana's Enrollee website, G&A department structure, and program highlights. This review was conducted based on information submitted by Humana through the RFI and through on-site meetings held on October 23, 2023. The on-site meetings involved key leadership from the MAO including but not limited to:

- Compliance Officer
- Associate Director, G&A
- Supervisor, G&A
- Market Leadership Advisor

- Project Manager

Overall Assessment

The grievance system follows standard processes. Grievances can be received from Enrollees, Enrollee representatives, or providers verbally through Customer Services call center or in-person at a service center, or be written (i.e., filling out a form on Humana's website and submitting it, fax, or mail). If a grievance is received verbally, the Customer Service Representative documents the grievance in MHK and routes it to the G&A department. This customer relationship management system is used as a repository and tracking system for all Enrollee Grievances received via Enrollee Services, the Service Centers, and the Pharmacy Department and is accessible to anyone in the company. Enrollee complaints are received and managed by the Customer Services call center. If the case is not resolved within 72 hours, the case is referred to the G&A department as a grievance. There are nine full-time employees dedicated to the Puerto Rico line of business for G&A management. Appeals are managed using the MHK system. G&A records are retained for 11 years.

Grievance staff facilitate the grievance investigation, producing and sending Enrollee notification letters, and coordinating investigations with other impacted business units. For example, the PNM team will be sent quality of service grievances; a QOC grievance is sent to the Quality team. MHK is used for tracking the timeliness of resolution and housing all grievance documentation. Grievance acknowledgement letters are sent within 10 business days and resolution letters within 30 calendar days of receipt of the grievance. Grievance data is shared with the Quality team on a quarterly basis.

Enrollee complaints are documented and tracked by Customer Service through a customer relationship management system. If the case is not resolved within 72 hours, the customer service representative refers the case to G&A Department as a Grievance. It is unclear whether complaints are tracked and trends identified. Grievances and complaints provide an opportunity to identify areas of improvement in the complete system of care; there is an opportunity for the MAO to create an integrated grievance, complaints, and appeals system that maximizes the use of grievance and complaints data for continuous QI.

Similar to grievances, standard appeals are accepted both verbally (through Enrollee Services) or in writing (appeals form can be found on the MAO's website or on the last page of the Enrollee's NOABD letter) and sent to Humana via US mail, fax, or Enrollee portal. Verbal appeals filed by providers are required to have written Enrollee consent. The appeal start date is the date the initial appeal is received. Humana's G&A policy indicates that "verbal appeals should be limited to illiteracy, handicap, or due to illness, Part D and expedited appeals". Humana explained during the on-site interview that verbal appeals do not need to be followed-up with a written appeal for the Medicaid population. There is an opportunity for the MAO to review their P&Ps to ensure there is no confusion between Medicare and Medicaid requirements.

Appeals staff are responsible for sending out Enrollee correspondence including the initial acknowledgement letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuity of care is requested in the appeal, the analyst checks to ensure the proper steps have occurred and timelines are met. The Enrollee or Enrollee representative has the opportunity to present the case and answer any questions.

The case is reviewed by the Regional Medical Director, and a decision is issued and communicated to the Enrollee verbally and written. If the case is overturned, the G&A representative sends the case to the UM department to upload the approval and create an authorization in the internal system. If the case is upheld, the G&A representative documents the decision and refers the case to a Maximus Specialist or G&A Supervisor. In the case of an upheld appeal decision when the Enrollee continues to receive benefits, it is unclear how/if the MAO takes steps to recover the cost of the service.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has a written grievance system under which Enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, Covered Services. The Grievance System includes a Complaint process, Grievance process, Appeal process, and access to the ALH process. (42 CFR part 422 Subpart M) (42 CFR Part 438, Subpart F) Platino Article 11.1; 11.1.2	Partially Met	Enrollee complaints are managed in Enrollee Services department rather than as an integrated component of the G&A System. (11.1.2)	Develop P&Ps to support contract requirements outlined in Article 11, including appropriate definitions for, and tracking and trending of complaint, grievance, and appeals data.
The MAO's P&Ps, Enrollee Handbook, and Provider Manual clearly state that an Enrollee may file an appeal orally or in writing within 60 calendar days after receiving an Adverse Benefit Determination and will acknowledge receipt of the appeal. The contractor shall acknowledge receipt of each appeal in writing within 10 business days. (42 CFR §438.402 (2)(ii)) (Platino 11.5)	Partially Met	The MAO's G&A management policy for how an Enrollee can request an appeal does not align with requirement to allow oral appeals to be treated as an appeal. (11.5) The NOABD letter template indicates that if the Enrollee calls the MAO to request an appeal, a summary of the call will be sent to the Enrollee. It does not indicate whether a written appeal would also be acknowledged or when. (11.5.6)	Review and revise G&A P&Ps and Enrollee materials to ensure Enrollees can file an appeal verbally or in writing and that all appeals are acknowledged in writing within 10 business days.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO's P&Ps clearly state time frames for standard resolution of appeals and notification of the decision within 30 calendar days. (42 C.F.R. §438.408) Written Notice of Disposition of an appeal is provided to the Enrollee ASES within two business days of the decision. (Section 11.5.10.1 and 11.5.13)	Partially Met	The MAO does not have a process in place to notify ASES within two days of an appeal decision. (11.5.13)	Develop a process for notifying ASES of appeal decisions and include in P&Ps revision or standard operating procedure.
The MAO's P&Ps define when and how the MAO may uphold a denial and recover the cost as applicable for services furnished while the appeal/ALH was pending. (42 CFR §438.420(d)) (Platino 11.7.4)	Not Met	The MAO does not have a policy that states the plan will not recover cost of services furnished while the appeal or ALH was pending from the Enrollee. (11.7.4)	Develop a P&P that states the MAO will not recover costs from the Enrollee for services that were furnished while an appeal/ALH is pending.
The MAO's P&Ps clearly defines how the MAO may reverse a denial and promptly authorize or provide the disputed services that were not furnished during the appeal process; and, that the MAO will pay for services received during the dispute. (Platino 11.7.5 and 11.7.6) (42 C.F.R. § 438.424)	Partially Met	The Medicare G&A Management policy provides a brief description of how an overturned appeal is managed; however, it does not contain timelines. (11.7.5)	Update P&P to reflect the timeline for effectuation of an overturned appeal.
The MAO's P&Ps explain the process to inform the Enrollee of their right to and procedures for requesting an ALH. (GHP 14.6) (42 CFR §438.408(f)) (Act 72 of Sept 7, 1993) (11.6.1)	Partially Met	Humana did not provide documentation that supports MAO contract requirements related to the Enrollee's ability to request an ALH if the MAO does not meet notification or timeline requirements. (11.6.1)	Update P&Ps and Enrollee materials to include appropriate language to ensure Enrollee rights and procedures to request an ALH according to 11.6.1 of the Platino contract.

QAPI Program

A review of the QAPI program includes the following:

- The presence of an ongoing comprehensive QAPI program
- Monitoring and assessment of the QAPI
- Analysis and reporting of the QAPI
- Performance measurement
- QI initiatives

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MAO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to , utilization, claims, G&A, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330.

The intent of this regulation is to ensure the MAO has an ongoing quality assessment and performance improvement program for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with SHCN.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Humana's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 23, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- Associate Director of Quality
- Project Manager
- Humana Director
- Market Leadership Advisor
- Associate Director, Regulatory Compliance, Audit Coordination

Overall Assessment

Mercer found all required documentation provided evidence of compliance with regulatory or contractual provisions. During the on-site review, Mercer also observed Humana MAO staff

provided responses that were consistent with each other and with the submitted documentation.

The Mercer assessment further found that the Humana MAO illustrates a well-developed QAPI program that is robust and comprehensive at the corporate as well as the local Puerto Rico level via its wide based and thorough systems, reports, and guidelines for all Enrollee ship types including Special Needs Plan and Medicare Advantage Plan Enrollees with special needs and disabilities. Multiple broad-based committees are incorporated at several levels with diverse SMEs as key staff who report, meet, evaluate, analyze, and report to its internal board at least quarterly. Continuous monitoring, evaluation, and analysis of the QAPI is well illustration through documented P&Ps within the QAPI description and in supporting policies.

Additionally, Humana MAO illustrates multiple monitoring entities, committees, and processes for the ongoing evaluation of key performance measures, QI projects, complaints, grievances, and appeals including related data trends, Enrollee access and availability indicators, Enrollee safety, pharmacy prescription, and over/under utilization. It is important to note that with the UM review, Humana UM staff confirmed that policy did not establish any utilization thresholds as they report the extreme variations from the COVID-19 PHE and Hurricane Maria did not allow for any stable utilization for comparison. Based on the documents and P&P reviewed for the QAPI program that included a thorough description for over/under utilization monitoring, this information presents an opportunity for Humana to enhance coordination and collaboration between its UM and QAPI programs. Additionally, cultural and linguistic appropriate services are in place and monitored which includes staff training, language tools, and an enterprise-wide risk assessment to ensure that Humana is meeting the needs of a diverse population. Thorough guidance and standards are further illustrated via the Clinical Practice Guidelines, Dental standards, QOC Concern Categories and Indicators, and the Guidelines for Agency for Healthcare Research and Quality serious reportable adverse events patient safety evaluation.

Humana’s multiple diverse committees, polices, and procedures illustrate ongoing and continuous assessment and analysis, UM, and QI, where committees meet monthly with diverse stakeholders focused on safety, efficiency, and other related potential gaps.

Lastly, the Humana MAO illustrates thorough comprehensive QIP descriptions. The PRMP does not direct the MAOs to develop specific PIPs, however, Humana’s policy ensures there are three active QIPs in place at all times that address opportunities for either error reduction or performance improvement. The three QIPs focus on clinical quality and at least one of the three addresses consumer safety for the population served. The CAHPS annual assessment is the basis for improvement initiatives as well as the HEDIS improvement initiatives. The MAO's CQIC oversees the QIP, as delegated by the Internal Board Management Team, and assumes the responsibility for the QIP of Humana. The CQIC provides guidance to leadership and staff related to QI priorities and projects to include Chronic Care Improvement Programs (CCIPs), Coordination of Care studies and state Specific Contractual Quality requirements. The Quality Operations Compliance and Accreditation is responsible for maintaining and managing documentation of the CCIPs. The mandated topic for the CCIP is “promoting effective management of chronic diseases”. Humana has selected Chronic Obstructive Pulmonary Disease as the specific condition to focus on for this study for three-year study cycle.

Findings

Humana met all requirements for these metrics through RFI documents, on-site discussions, and post on-site submissions.

MCS

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MCS' organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 24, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- VPs
- Directors
- SVP
- AVPs
- Managers
- Directors
- Analysts
- Product Development

Strengths

The MCS team showed engagement and willingness to participate in on-site discussions which provided additional detail to abiding by the Code of Federal Regulations and the Platino contract.

Opportunities for Improvement

While Mercer found MCS to have several procedures in alignment with 42 CFR and the Platino contract, it was also observed that there is the need to review and revise or develop new P&Ps to ensure that all federal and contractual requirements are followed.

MCS submitted several policies that speak to the requirement of services being provided in a culturally competent way but did not provide a Cultural Competency Plan, highlighting the opportunity to develop a detailed and comprehensive Cultural Competency Plan.

Enrollee complaints are documented and tracked by customer service. It is unclear whether complaints are tracked and trends identified.

Recommendations

Review and revise available P&Ps to ensure regulatory and contractual compliance. Provide training to staff on newly developed and revised P&Ps.

Develop a comprehensive Cultural Competency Plan and ensure all staff are provided initial and annual training thereafter.

The MAO should explore opportunities to create an integrated grievance, complaints and appeals system that maximizes the use of grievances and complaints data for continuous QI.

Administration and Organization

Overview

Organizational Structure

MCS Platino organizational structure includes a corporate board of directors which provides oversight to the audit, compliance, investments, independent directors, and compensation committees. Organizational charts reflect the reporting and departmental structure. The CEO oversees a team of VP, SVP, and C suite positions, who, in turn, oversee the following departments: Enrollee Services, Quality, Provider Operations, Pharmacy, Clinical Operations, Utilization Management, Network Management, Clinical Affairs, and Customer Service. As of December 2022, MCS had a total of 2,361 staff. The largest departments are Call Centers (392), Membership (362), and Clinical Affairs (294). MCS offers both Platino and Commercial lines of business in Puerto Rico and all staff are fully dedicated to Puerto Rico business.

Delegated Entities

MCS delegates responsibilities to five different entities outlined in the table below. MCS has a fully centralized Delegation Oversight unit to evaluate and monitor MCS subcontractors' operations. MCS has P&Ps in place operationalizing the auditing, oversight, and monitoring of delegated polices. These policies describe audit and corrective action procedures, protection of PHI and requirements pertaining to sub-delegation.

Delegated Entity	Type of Entity and Services
Elixir	Pharmacy Benefit Services.
Eye Management of Puerto Rico (EMPR)	Vision Services — contracting, credentialing, and re-credentialing of optometry providers, providers, call center, and vision claims processing.
Episouce	Encounter Data Submission.
First Health Care (FHC) Health System of Puerto Rico	MH Provider Services — contracting, credentialing, and re-credentialing of MH providers, provider and Enrollees' call

Delegated Entity	Type of Entity and Services
	centers, pre-service organization determinations and appeal.
Net Claims Solution	Dental Management Services — claims processing, direct Enrollees reimbursements, dental pre-service platform.
TNPR — also known as HN1	Physical, Occupational, and Speech Services — provider contracting, and credentialing and re-credentialing of providers, providers call center, pre-service organization determinations and claims processing.

Accreditation

Health Plan accreditation is not a contract requirement. MCS has a full three-year accreditation with Accreditation Association for Ambulatory Health Care effective June 28, 2021. Reaccreditation is planned for June 2024.

Employee Training

All staff are provided with a comprehensive Training Plan. All new associates complete training on advance directives, grievances and appeals, cultural competency, FWA, HIPAA, sexual harassment and domestic violence protocols. Annually thereafter, employees receive training on advance directives, FWA, prevention and detection of financial exploitation, cultural competency, and HIPAA. Other trainings are dependent on specific positions and department. Training for all new hires and annual trainings are tracked and reported.

Enrollee Rights and Protections

A review of Enrollee rights and protections covered the following areas:

- Disenrollment requirements and limitations
- Enrollee rights requirements, including Enrollee rights and responsibilities, advance directives, the right to receive information, and moral and religious objections
- Information requirements for Enrollees

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MAO complies with the State enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MAO has written policies related to enrollee rights and ensure the MAO complies and holds staff and affiliated providers accountable to comply with enrollee rights and applicable State and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 438.10.

The intent of these regulations is to ensure the MAO provides appropriate information to enrollees and potential enrollees in a language and format that is easily understood. The MAO must inform enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MAO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (j).

The intent of these regulations is to ensure the MAO maintains P&Ps related to advance directives, including their rights under State law, and must contain clear and concise language on the limitation if the MAO cannot implement an advance directive as a matter of conscience. The MAO is responsible for providing enrollees with periodic written information regarding advance directives and their rights under the State laws. The MAO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MAO informs enrollees of their right to receive information and to receive that information in a timely manner. The MAO is responsible for ensuring enrollees have the right to participate in decisions regarding their care, to be free from any from or restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MAO provides the enrollee with information, including enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MCS' RFI response, consisting of policies, procedures, processes, workflows, and supporting documentation, including the Enrollee Handbook, Enrollee materials, provider manuals, provider bulletins, staff handbooks, training material, training schedules, and MCS' Enrollee website. This review was conducted based on information submitted by MCS through the RFI and through on-site meetings held October 24, 2023. The on-site meetings involved key leadership from the MAO including, but not limited to:

- Marketing Material Director
- Health Promotion and Wellness Director
- Health Promotion and Wellness AVP
- Customer Service
- Compliance Representative
- Enrollment Manager
- Reconciliation Manager
- Product Development
- Enrollment Representative

Overall Assessment

Disenrollment Requirements and Limitations

MCS has a strong process in place to ensure the plan is compliant with all CFR and contractual requirements pertaining to Enrollee involuntary and voluntary disenrollments. There are clear written P&Ps for processing both voluntary and involuntary disenrollments. MCS monitors and audits all disenrollment processes, requiring direct communication and coordination with the Compliance Department and CMS account manager. The Enrollment Manager ensures all disenrollments are processed daily.

For voluntary disenrollments, Customer Service Representatives (CSRs) are responsible for the processing the initial request associated with these disenrollments. MCS requires voluntary disenrollment requests must be in writing, dated, and signed. Once received, the disenrollment request letter is then forwarded to the Enrollment Department. Disenrollment requests are processed and confirmed by the Enrollment Analyst in accordance with the regulation.

MCS provided notification processes for exercising disenrollment rights, as well as the alternatives available to the Enrollee based on their specific circumstance. Through the EOC, MCS notifies all Enrollees, at least once a year, about their right to end their membership in the plan, the applicable Medicare rules, and their options to obtain other healthcare plan and/or prescription drug coverage.

Enrollee Rights Requirements

MCS has a strong process in place with written P&Ps to ensure compliance with all federal and Puerto Rico laws pertaining to Enrollee rights. Enrollee rights are outlined in the Enrollee Handbook and Enrollees are educated on how to exercise this right upon enrollment and annually, thereafter. MCS also meets the federal regulation and contract requirements for notification of Enrollees regarding advance directives. The Enrollee Handbook outlines Enrollee rights to file complaints concerning non-compliance with Advance Directive requirements directly with ASES or with the Puerto Rico Office of the Patient Advocate. The

plan has P&Ps in place for Enrollees to request and receive a copy of medical records and request to amend or correct the record as specified in federal regulations.

MCS does not have P&Ps outlining the process for moral and religious objections. Contract requirements and federal regulations requires that providers who elect not to provide, not to reimburse, or not to provide a referral or PA for a service within the scope of the detailed covered service, must notify ASES and Enrollees within a required timeframe. Following the on-site, the plan submitted a copy of the PCP Services agreement, however, the agreement did not provide reference to moral or religious objections made by a provider or issue guidance to providers on how to notify the plan, ASES and the Enrollee, should a moral or religious objection occur. MCS will need to develop guidance for providers regarding moral or religious objections that meet contractual and CFR requirements.

MCS provides training to staff related to Enrollee rights and protection annually and educates network providers about Enrollee rights and protections through the Provider Manual and Provinet (MCS provider web page). To ensure staff are educated about their responsibilities regarding Enrollee and potential Enrollee information requirements, all staff are required to attend a Customer Service Representative Academy provided within six weeks after hiring. These trainings are conducted by a training specialist or SME. Staff are trained annually, or more frequently, if necessary, according to changes in regulations, applicable laws, and other requirements or if the process needs reinforcement. All CSRs are trained on the following topics, but not limited to, Services Provided with Cultural Competence Manner, P&P of Call Center Call Management, Classicare Products (Individual, Special Needs Plans, Employer), Part D Benefits and Procedures, Medicare and You, ANOC, Marketing Material Benefits, Web page, and the Enrollment process.

New staff must achieve a minimum passing score of at least 85% or higher (as applicable) in all training tests. If the new employee does not get the minimum score required, there are two opportunities to retake the test. If the new employee does not achieve the passing score on all tests within the opportunities given (three opportunities in total), staff require remedial action, which may include feedback from the Training Specialist, Supervisor, or Human Resources Business Partner, re-testing, and employment termination.

Current staff must pass each annual test with a score of 85% or higher. To monitor compliance, current staff are assessed and evaluated on the quality of service and accuracy of information provided to all MCS insured and prospective clients according to MCS quality standards of service. This quality process is performed by the Financial Analysis Unit monthly and CSR supervisor. The Quality Specialist evaluates a volume of three calls per CSR. Each CSR has a total of six evaluations during the year. The Call Center Supervisor monitors three calls for each representative under his/her supervision.

Information Requirements for Enrollees

MCS complies with all CFR and contractual requirements pertaining to information requirements for Enrollees. Each Enrollee is provided with an Enrollee handbook, which serves as a summary of benefits and coverage, at enrollment and annually. Enrollees receive written notice of significant changes, at least thirty days before the intended effective date of the change.

Enrollees and potential Enrollees are informed that documents are available in alternative formats and how to access those formats through regulated marketing materials, such as the ANOC and the EOC. The plan has several P&Ps outlining alternative formats.

The MCS Compliance Department is responsible for ensuring that all materials intended for Medicare beneficiaries, prospects, and Enrollees meet the applicable CMS communication standards as outlined in the CMS Medicare Communications and Marketing Guidelines as amended and published annually. The MCS Compliance Department conducts a comprehensive review of the communication or marketing material using the Communications and Marketing Materials Review Checklist to ensure the material meets all the regulatory requirements. Every database used to manage Enrollee material requests must have a column including information of preferred language as well as alternate formats. When a request for written communication in additional languages is received, a representative validates the request and coordinates the translation with the Marketing Department. Once additional language material other than Spanish/English is received from the translator, the Marketing Traffic Specialist proceeds to process the delivery. These special requests are sent via certified mail.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has P&Ps in place to ensure: (5.5.1-5.5.3) If, during the course of the Contract period, pursuant to 42 CFR 438.102, the Contractor elects not to provide, not to reimburse for, or not to provide a Referral or PA for a service within the scope of the detailed Covered Services, because of an objection on moral or religious grounds, the Contractor shall notify ASES within 120 calendar days before adopting the policy with respect to any service; Enrollees within 90 calendar days after adopting the policy with respect to any service; and Enrollees before and during Enrollment. The Contractor shall furnish information about the services it does not cover based on a moral or religious objection to ASES.	Not Met	P&Ps were not submitted for notification requirements to the plan, ASES and Enrollees when providers issue a moral or religious objection.	Develop or revise P&P with clear guidance to providers regarding notification requirements to the plan, ASES and Enrollees when providers issue a moral or religious objection.

Provider Network — Access and Availability

A review of the provider network covered the following areas:

- Availability of services
- Furnishing of services and timely access

- Access and cultural considerations
- Assurances of adequate capacity and services
- Provider credentialing
- Sub-contractual relationships and delegation
- Practice guidelines

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MAO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MAO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MAO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MAO has written P&Ps for the selection and retention of providers and a documented process for the initial and recredentialing of providers. Regulation 438.214(c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214(d) prohibits the MAO from contracting with providers that are excluded from participation in Medicare and State health care programs.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with State requirements. The MAO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network (OON).

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MAO has P&Ps in place which guarantee the MAO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MAO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The intent of these regulations is to ensure the MAO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MAO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers, and financial considerations.

The following federal regulation is addressed in this section: 438.104.

The intent of this regulation is to ensure the MAO obtains State approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MCS' organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through an on-site meeting held on October 24, 2023. The on-site meeting involved participation from MAO key leadership including, but not limited to:

- SVP, Network Management
- VP, Network Operations
- AVP, Provider Operations
- Credentialing Manager
- Compliance

Overall Assessment

MCS provided comprehensive documentation regarding their Medicaid service network. Mercer found most Platino Model Contract and CFR requirements were documented in the materials submitted for the desk review. MCS staff provided consistent responses during the on-site and submitted the requested follow-up documents on time. The follow-up documents submitted provided evidence of contractual provisions in all but one area.

MCS presented with strong leadership and passion for their Enrollees. They consistently monitor the network to ensure access is readily available for Enrollees. The user-friendly online provider directory covers provider capacity, cultural competency, handicap accessibility, languages spoken, affiliations, and hours of operation. MCS keeps a thorough review and reporting process in place, ensuring that the network has a sufficient array of providers, and that providers meet timely access requirements, maintain required hours of operation, and offer accessible physical locations and accommodations when needed.

MCS provided EOC for the required areas of women's health specialist for routine and preventive healthcare services, the ability to obtain a second opinion, in- or- OON, at no cost to the Enrollee, and adequate and timely access and coverage for Network Providers as well as OON services if MCS is unable to provide such access.

MCS maintains a large network of providers and subcontractors and provided supporting documentation that reflects an appropriate range of preventive, primary care, and specialty services that are adequate to serve the expected number of Enrollees in its service area. No exceptions to the required number of providers were needed in CY 2022. MCS ensures

providers are enrolled through the MMIS system, provider contracts cover all required details regarding obligations and covered services. Providers are given a thorough orientation and ongoing education and supports are provided through quarterly network updates and additional updates as needed, specifically with updates to the Provider Manual, Quick Reference Guide and/or Provider Bulletins to comply with state and federal laws. Providers are trained on the G&A process during orientation. As an effort to maintain network adequacy, MCS monitors the existing networking using Health Service Delivery tables and geographic access tools, and contracts with new providers as available to ensure the provision of services are available.

MCS has a centralized unit — Delegation Oversight Unit — dedicated to evaluating and monitoring all MCS subcontractors' operations. The Delegation Oversight Unit performs these functions in close coordination with the internal business owners and the MCS Compliance Department. The Delegation Oversight Unit's key functions are as follows:

- Monitor the subcontractors' performance guarantees in accordance with the agreements.
- Support the pre-delegation audit process conducted by the Compliance Department.
- Handle the Compliance Subcontractor Dashboard which is a tool that documents monthly results for each entity. This tool helps to correctly monitor and assess the compliance with the contract as well as regulatory requirements.
- Identify non-compliance issue and negative trends.
- Lead the Delegation Oversight Committee on a quarterly basis to discuss with SMEs from all key area's trends, issues, and updates from the entities.
- Provide a summary to the Corporate Compliance Committee on a quarterly basis.
- Work with internal action plan for any changes and improvement implementation as well as monitoring of any findings.

The following table outlines the subcontractors that support Provider Network functions.

Delegated Entity	Type of Entity and Services
Elixir	Pharmacy Benefit Services.
EMPR	Vision Services — contracting, credentialing, and re-credentialing of optometry providers, providers call center and vision claims processing.
FHC health System of Puerto Rico	MH Provider Services — contracting, credentialing, and re-credentialing of MH providers, provider and Enrollees' call centers, pre-service organization determinations and appeal.
TNPR — also known as HN1	Physical, Occupational and Speech Services — provider contracting, and credentialing and re-credentialing of

Delegated Entity	Type of Entity and Services
	providers, providers call center, pre-service organization determinations and claims processing.

MCS has P&Ps in place that ensures provider contracts are consistent with the Platino contract requirements. MCS has a detailed credentialing and re-credentialing process as evidenced through the materials reviewed during the desk review. MCS submitted multiple policies regarding provider termination, and the follow-up documents clarified the communication to ASES as part of the process, which occurs through the Compliance Department.

MCS provided the policy documenting that services are to be provided in a culturally competent manor, this is specifically included in provider contracts. Provider education/training includes cultural competency training at new employee orientation, annual training, and specialized training to reinforce deficiencies that have been reported to the compliance department. However, a detailed and comprehensive Cultural Competency Plan was not submitted.

Provider guidelines meeting contract requirements are covered in the Provider Handbook, as well as provider manuals which are distributed within 15 days of contracting as part of the Network Provider Orientation and Education program. MCS submitted manuals for Classicare, EMPR, and TNPR.

Number of MCS Platino Contracted Providers in 2022

Provider Type	Number of Provider Types in 2022
PCP	3,134
PMG	25
Hospital	67
Urgent care	72
Nursing facility	4
Dental	1,145
Vision	1,374
BH	2,337
FQHC	19
Other	6,094
Other, Speech Therapy	44
Other, Physical Therapy	164
Other, Occupational Therapy	40
Other, Physical Medicine and Rehabilitation	144

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
MAOs have P&Ps in place to (7.2.1.29) Require that the Provider comply with the Contractor's Cultural Competency Plan; (4.5.1) (42 CFR 438.206), have a comprehensive written Cultural Competency Plan describing how the Contractor will ensure that services are provided in a culturally competent manner to all Enrollees.	Partially Met	The MAO submitted several policies that speak to the requirement of services being provided in a culturally competent way but did not submit a comprehensive written Cultural Competency Plan.	Develop a comprehensive written Cultural Competency Plan.

Coordination and Continuity of Care

A review of the coordination and continuity of care covered the following areas:

- Identification of populations with SHCN
- Enrollee monitoring for medical conditions suggesting a need for care or disease management
- Protection of Enrollee records from unauthorized disclosure per the HIPAA Privacy and Security standards

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MAO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to enrollees with SHCN, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated CC program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize QOC and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MAO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MCS' organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 24, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- Providers Communication Specialist
- Compliance Auditor
- Clinical Administration AVP
- SVP Premium Management
- Clinical Review AVP
- CM Director
- Special Clinical Program Director
- Quality Evaluation Analyst
- Transition of Care Director
- Special Needs Plan Manager

Overall Assessment

Mercer found all required documentation provided evidence of compliance with regulatory or contractual provisions. During the on-site review, Mercer observed MCS MAO staff provide additional material and documents, further demonstrating and confirming their compliance.

MCS provided a comprehensive set of policies outlining their well-documented processes for CM assignment, engagement, and privacy requirements for providers and Enrollees, including verification of legally responsible individuals involved in care.

The on-site review with MCS supported the MAO's RFI response and deliverables, observing staff's ability to demonstrate their knowledge and implementation of the policies in place. MCS provided policies outlining processes for the Comprehensive HRA completion within 90 calendar days of enrollment and annually, as well as protocols to ensure multiple attempts for engagement with beneficiaries in care coordination services. When beneficiaries are unable to be contacted, MCS has procedures in place to mail a HRA to the Enrollee for

completion and engage the PCP for support with HRA completion when indicated. Additionally, MCS data identifies individuals that automatically score at a higher risk leading to more intense CM such as Acute CM, Complex CM, or Chronic CM.

Lastly, MCS staff demonstrated they have P&Ps that established a methodology to identify populations with SHCN, as well as beneficiaries that would benefit from a treatment plan and regular care monitoring. MCS illustrated P&Ps that ensure beneficiaries transitioning out of hospitals receive transition of care services to link them to follow-up and after care services as well as strategies to coordinate care for Enrollees being discharged with processes in place to support Enrollees experiencing barriers to accessing treatment. Additionally, MCS demonstrated policies that include monitoring and oversight for appropriate CM and referrals to CM and Disease Management services.

Findings

MCS met all requirements for these metrics through RFI documents, on-site discussions, and post on-site submissions.

UM

A review of UM covered the following areas:

- Coverage and authorization of services
- Compensation for UM activities
- Emergency and post-stabilization services
- Timeframes for authorization decisions
- Prescription drug authorization requirements
- Adverse benefit determination

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MAO, with input from providers, has clinical practice guidelines in place that reflect the needs of enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MAO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MAO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MCS organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 24, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- VP Medical Affairs
- AVP Clinical Administration
- UM Director
- Transition of Care Director
- Appeals Director
- Senior Compliance Auditor

Overall Assessment

The UM department provides prior authorization, concurrent and retrospective review for UM decision making, and the timeframes and timelines are well defined through the UM program description and P&Ps. The UM program description is updated at least annually and is included in the QM evaluation.

UM staffing is based on membership, case rates, and caseloads. The department is structured to include one team for PA and one team for concurrent/retrospective reviews. Concurrent review is primarily done on-site at the contracted hospital facilities. The teams include registered nurses and non-clinical coordinators. All clinical staff and peer reviewers are licensed in Puerto Rico and are fully dedicated to Puerto Rico. Clinical consultation is available with a licensed supervisor or a physician. Upon hire, UM specialists begin orientation with a Clinical Training Specialist. Training is coordinated with the Training and Development Unit, UM supervisor, and UM director. A comprehensive training plan is in place for UM to address the requirements of the P&Ps and support staff in performing job duties. IRR is conducted at least annually through the InterQual platform with a required passing rate of 80%–85%. UM supervisors or designated audit staff conduct monthly quality audits which are part of the annual performance evaluation of the staff.

For UM decisions, MCS utilizes InterQual, CMS local coverage determinations, and specialty societies such as American College of Cardiology and Radiology. InterQual is embedded into the clinical system and other criteria sets are accessed through links in the TruCare system.

Clinical Guidelines are evaluated by the Puerto Rico PRC and approved by the CMO at least annually.

UM trends are evaluated quarterly during UM committee meetings and then reported to the quality committee meetings. When a trend is identified, the committee discusses an intervention. For example, total knee replacements were above utilization thresholds, and a PA process was introduced.

MCS has a policy for the adoption and promotion of nationally recognized CPGs and have a wide array of CPGs in place including diabetes care, substance use, and immunizations. The development, adoption, approval, communication, and revision of CPGs is the responsibility of the Clinical Medical Policy Unit.

MCS has a fully centralized delegation oversight unit to evaluate and monitor subcontractor operations. The Delegation Oversight Unit works closely with the compliance department to monitor performance in accordance with the agreements, support the pre-delegation audit process, manage the Compliance Subcontractor Dashboard, lead the delegation Oversight Committee, and provide summaries to the Corporate Compliance Committee. There are two delegated entities that perform UM functions:

- FHC System of Puerto Rico, which is a fully delegated arrangement and is responsible for the BH UM including prior authorization, clinical concurrent reviews, discharge planning, medical necessity review, physician consultation and handling appeals. FHC utilizes InterQual, CMS national and local coverage determination, and diagnostically based clinical guidelines. FHC has its own UM committee but also participates in MCS'. MCS and FHC review their services subject to UM and compare policies to ensure requirements are comparable and not more stringent for BH services. Efforts are currently underway to develop a parity audit process and requirements.
- TNPR — also known as HN1, which is responsible for preservice organization determinations of therapy services. TNPR is only delegated for approvals and will refer cases back to MCS for review if criteria are not met.

The MAO staff provided responses that were consistent with each other and the documentation regarding the timeframe for PA decisions and providing written notice of adverse benefit determinations.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has written P&Ps that: (i) identify, define, and specify the amount, duration, and scope of covered services available under the contract and how and where to access such services; (42 C.F.R. § 438.10. Platino section 4.3.1.2)	Partially Met	The EOC document includes the coverage of services available to Enrollees. FHC and MCS conduct an evaluation to review UM policies and coverage. MCS is	Submit P&Ps that outline the MAO's process to ensure authorization requirements comply with parity requirements.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has P&Ps to ensure its PA requirements comply with the requirements for parity in MH and SUD benefits under 42 C.F.R.§ 438.910(d) (Platino 5.3.9.2)		in the process of developing parity audit processes. No policy was submitted.	
The MAO has written P&Ps that prohibit the MAO or any delegated UM agent from providing compensation or anything of value to its employees, agents, or contractors based on: either a percentage of the amount by which a claim is reduced for the payment or the number of claims or the cost of services for the denied authorization or payment; or any other method that encourages a decision to deny, limit, or discontinue a Medically Necessary covered service to any Enrollee. (Platino 8.2.4) (42 C.F.R. § 438.210(e))	Partially Met	FHC UM Policy Objectivity in clinical decision-making outlines this procedure for FHC employees. Specific policies were not found for MCS or TNPR.	Submit MCS P&Ps that prohibits the MAO or any delegated UM agent from incentivizing UM decisions.

G&A

A review of G&A covered the following areas:

- General grievance system requirements, including:
  - Information about the grievance systems shared with providers and subcontractors
  - Grievance system P&Ps
  - Authority to file
  - Handling of G&A
  - Recordkeeping requirements
- Grievance system management, including the grievance process, resolution, and notification
- Appeals process management, including the appeals process, resolution, and notification

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MAO has in effect a grievance and appeal system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MAO must inform members of how to access the grievance system, the availability of the MAO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MAO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MAO provides NOABD letters that are compliant with language, content, and format as required by enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MAO provides enrollees with assistance, if requested, to complete processes within the grievance system. The MAO has processes in place ensuring enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MAO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MAO must keep a log of all G&As filed. The MAO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate MCS' compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MCS' RFI response and supporting documentation including P&Ps, Enrollee Handbook, Enrollee website, G&A department structure, and program highlights. This review was conducted based on information submitted by MCS through the RFI and through on-site meetings held on October 24, 2023. The on-site meetings involved key leadership from the MAO including but not limited to:

- Director, Clinical Operations
- SVP, Clinical Affairs
- VP, Clinical Administration
- AVP, Clinical Operations
- Analyst, G&A Monitoring
- Manager, Grievances and Appeals
- Senior Specialist, Grievances and Appeals
- Senior Compliance Auditor
- Specialist, Provider Communications

Overall Assessment

Enrollee complaints are received and managed by the Customer Services call center. If the case is not resolved within 72 hours, the case is referred to the G&A department as a grievance. The grievance system follows standard processes. Grievances can be received from Enrollees, Enrollee representatives, or providers verbally through Customer Services call center or in-person at a service center, or be written (i.e., filling out a form on MCS' website and submitting it via fax or mail). If a grievance is received verbally, the Customer Service Representative documents the grievance in Beacon Healthcare System (Beacon) and routes it to the G&A department. This customer relationship management system is used as a repository and tracking system for all Enrollee grievances received via Enrollee Services, the Service Centers, the Pharmacy department, and is accessible to anyone in the company. Appeals are managed using the TruCare system. MCS delegates Enrollee grievances and appeals related to MH services to FHC. FHC follows the same process for receiving and resolving grievances and appeals.

Grievance staff facilitate the grievance investigation, producing and sending Enrollee notification letters, and coordinating investigations with other impacted business units. For example, the PNM team will be sent quality of service grievances and a QOC grievance is sent to the Quality team. QOC grievances are tracked and reported to the QIC and if the Enrollee has a case manager assigned, they are notified as well. Beacon is used for tracking the timeliness of resolution and housing all grievance documentation. The timeframe for grievance resolution starts the day the MAO receives the initial complaint or grievance. Grievance acknowledgement letters are sent within 10 business days and resolution letters

within 30 calendar days of receipt of the grievance. MCS monitors Enrollee satisfaction with its services and identifies areas for improvement on a quarterly basis using the G&A data.

Enrollee complaints are documented, tracked, and metrics are monitored by Customer Service department through a customer relationship management system. If the case is not resolved within 72 hours. the customer service representative refers the case to G&A department as a grievance by completing a form and emailing it to the G&A department. If the Enrollee does not wish to formally file a complaint, the issue is logged in Beacon but a formal investigation does not take place. It is unclear how the MAO integrates complaint data with grievance data for a more complete view of Enrollee issues. For grievances that start as a complaint, the time spent on investigating the complaint is deducted from the 30-day resolution timeline for grievances.

Similar to grievances, standard appeals are accepted both verbally (through Enrollee Services) or in writing (appeals form can be found on the MAO's website) and sent to MCS via US mail, fax, or Enrollee portal. Verbal appeals filed by providers are required to have written Enrollee consent. The appeal start date is the date the initial appeal is received. There is an opportunity for the MAO to review their P&Ps to ensure there is no confusion between Medicare and Medicaid requirements and that definitions are aligned with the Platino contract.

Appeals staff are responsible for sending out Enrollee correspondence including the initial acknowledgement letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuity of care is requested in the appeal, the analyst checks to ensure the proper steps have occurred and timelines are met. The Enrollee or Enrollee representative has the opportunity to present the case and answer any questions. A G&A technician or specialist logs the appeal in TruCare (dental and Part B drug appeals are registered and managed in Beacon). The case is reviewed by a physician, and a decision is issued and communicated to the Enrollee verbally and written. If the case is overturned, the G&A specialist coordinates services as expeditiously as the Enrollee's health requires (no later than 30 days). If the case is upheld, the G&A representative documents the decision and refers the case to a Maximus Specialist or G&A Supervisor. In the case of an upheld appeal decision when the Enrollee continues to receive benefits, the MAO does not recover costs for those services.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has a written grievance system under which Enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, Covered Services. The Grievance System includes a	Partially Met	Enrollee complaints are managed in Enrollee Services department rather than as an integrated component of the G&A System. (11.1.2)	Develop P&Ps to support contract requirements outlined in Article 11 including appropriate definitions for and tracking and trending of complaint, grievance, and appeals data.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
Complaint process, Grievance process, Appeal process, and access to the ALH process. (42 CFR part 422 Subpart M) (42 CFR Part 438, Subpart F) (Platino 11.1; 11.1.2)			
The MAO's P&Ps ensure continuation of benefits while the MAO appeal and ALH are pending. (42 C.F.R. § 438.420) (Platino 11.7)	Partially Met	The MAO's policy on continuation of benefits does not reflect contract language in 11.7.3.3.	Review and revise policy CL-GA-037 on continuation of benefits to align with the Platino contract and ensure staff training and implementation.

QAPI Program

A review of the QAPI program includes the following:

- The presence of an ongoing comprehensive QAPI program
- Monitoring and assessment of the QAPI
- Analysis and reporting of the QAPI
- Performance measurement
- QI initiatives

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MAO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to , utilization, claims, G&A, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330.

The intent of this regulation is to ensure the MAO has an ongoing quality assessment and performance improvement program for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with SCHN.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MCS' organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 24, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- Compliance Auditor
- QI VP
- Clinical Quality Specialists
- Clinical Improvement Manager
- Quality Director

Overall Assessment

The Mercer assessment found all required documentation provided evidence of compliance with regulatory or contractual provisions. During the on-site review, Mercer observed MCS MAO staff provided responses that were consistent with each other and with the submitted documentation.

Additionally, the MCS MAO illustrates a thorough comprehensive ongoing QAPI program description with all essential elements for oversight, performance improvement projects implementation and monitoring of processes to assess over and underutilization, quality and appropriateness of care rendered, quality of appropriateness of long-term care, and identify, remedy, and prevent critical incidents.

The MCS MAO also illustrates a thorough and robust monitoring process with multiple layers of reporting entities and oversight. The QIC is responsible for oversight of the MCS QIP and is accountable to the MCS Board of Directors. MCS defined its purpose of the QI program as a process to provide the infrastructure for continuous monitoring, oversight, evaluation and improvement in care, safety and services. Monitoring activities include utilization management, CM, disease management, risk management, patient safety, provider credentials, claims, customer service, and network development. MCS utilizes a Model of Care (MOC) effectiveness approach for its CCIP and Dual Special Needs Plan monitoring. Additionally, the MCS QI program includes an Enrollee Satisfaction Committee, integrating and evaluating the results from its CAHPS as well as an annual Simulated Satisfaction Survey through an approved CAHPS vendor. This survey is deployed in the off-season and is similar to CAHPS, with the exception of it being unblinded so that both Enrollee and provider are known to MCS, allowing MCS to take action. A board of directors is a governing body and has ultimate accountability.

Lastly, the MCS MAO illustrates a comprehensive process for QIP and PIP programs via the 2022 Telemedicine QIP for Medicare Advantage programs and Special Needs Plan QIP project on Statin medication adherence, completed in December 2021. The PRMP does not direct the MAOs to develop specific PIPs, however, MCS utilizes a comprehensive QI

methodology for establishing QIPs and PIPs throughout the year to ensure CMS compliance and predictable achievability.

Findings

MCS met all requirements for these metrics through RFI documents, on-site discussions, and post on-site submissions.

MMM Platino

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 25, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- CEO/President
- VP
- AVPs
- Senior Directors
- Directors
- Associate Directors
- Senior Officers
- Supervisors
- Area Leads
- Project Managers
- Advisors
- Legal

Strengths

The MMM Platino team showed engagement and willingness to participate in on-site discussions which provided additional detail to abiding by the Code of Federal Regulations and the Platino contract. All employees of MMM Healthcare, LLC. are dedicated to work in Puerto Rico.

MMM Platino has a NCQA accreditation for the NCQA Population Health Program, with the most recent review in July 2022. Re-accreditation is due in April 2025/June 2025 and the plan is seeking a new accreditation for Health Equity in November 2023.

It was also noted during the MMM Platino review that the on-line directory identifies if the provider performs home visits and provides a link that Enrollees may use to request further information on the provider's credentials.

Opportunities for Improvement

There is an opportunity for MMM Platino to review and revise or develop P&Ps to ensure all federal and contractual requirements are followed.

There is an opportunity for MMM Platino to review the PA process to reduce burden on the Enrollee.

Recommendations

Review and revise available P&Ps to ensure regulatory and contractual compliance. Provide training to staff on new developed and revised P&Ps.

Review the process for prior authorizations to reduce Enrollee burden.

Administration and Organization

Overview

Organizational Structure

MMM administers its Platino plan under MMM Healthcare, LLC., a subsidiary of MMM Holdings, LLC. MMM Healthcare LLC. Operates under a corporate board of directors which oversees an executive leadership team. This executive leadership team is the same for all lines of business under MMM Holdings, LLC., and includes a Compliance Officer, the COO, the CMO, the Quality Management/Five Star Operations VP, and legal counsel. QM and clinical services are overseen by the Quality Management/Five Star Operations VP, the COO oversees Enrollee, and the CMO oversees UM and grievances and appeals. All employees of MMM Healthcare, LLC. are dedicated to work in Puerto Rico.

Delegated Entities

MMM Platino delegates responsibilities to five entities described in the table below.

Delegated Entity	Type of Entity and Services
ATENTO	Beneficiary call center.
CVS Caremark Corporation	Pharmacy benefit management.
Insight	Provider call center for after-hours calls.
MC-Rx (formerly MC-21 Inc.)	Pharmacy benefit management.
MSO of Puerto Rico	UM, clinical services (PH and MH), claims, pharmacy, HRA, contracting, credentialing, and network management. Audits and monitors contracted delegated entities.

Under the MSO of Puerto Rico, a related entity to MMM Healthcare LLC., the following entities are sub-delegated.

Delegated Entity	Type of Entity and Services
EMPR	Vision Services — contracting, credentialing, and re-credentialing of optometry providers, providers call center, and vision claims processing.
InHealth Management	Hospital UM.
INSPIRA	MH Services — contracting and credentialing of MH providers.
Net Claims Solution	Dental Services — claims processing, direct members reimbursements, dental preservice platform.
Telemedik	PSG Call Center Medicaid.
TNPR — also known as HN1	Physical, Occupational, and Speech Therapy — contracting, credentialing, and re-credentialing of providers, providers call center, pre-service organization determinations, and claims processing.

MMM Platino has P&Ps in place which operationalize the monitoring, oversight, and auditing of delegated entities and provided evidence of similar policies utilized by MSO of Puerto Rico for sub-delegates. MMM Platino and MSO of Puerto Rico have dedicated Delegation Oversight Units, which are responsible for contract and regulatory oversight of their delegated entities. The Delegation Oversight Unit under MMM Platino falls under the Compliance Department within MMM Healthcare's organizational structure. Under the MSO of Puerto Rico, the unit reports directly to the MSO's Provider Internal Operations department.

Accreditation

Although not a contractual requirement, MMM Platino has an NCQA accreditation for the NCQA Population Health Program, with the most recent review in July 2022. Re-accreditation is due in April 2025/June 2025 and the plan is seeking a new accreditation for Health Equity in November 2023.

Employee Training

MMM Platino has an established training program for new hires, subcontractors, and providers offered virtually or via an online educational platform. MMM Platino requires new hire training within 90 days of hiring and requires either an exam or an attestation of completion. All subcontractors must present attestations as proof of completion. Staff are trained in advance directives, cultural competency, FWA, HIPAA, BH, Enrollee rights, G&A, Medicaid and covered Medicaid services, the MMM Platino compliance plan, Code of Conduct, and the financial exploitation of aging adults and adults with disabilities.

Enrollee Rights and Protections

A review of Enrollee rights and protections covered the following areas:

- Disenrollment requirements and limitations

- Enrollee rights requirements, including Enrollee rights and responsibilities, advance directives, the right to receive information, and moral and religious objections
- Information requirements for Enrollees

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MAO complies with the State enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MAO has written policies related to enrollee rights and ensure the MAO complies and holds staff and affiliated providers accountable to comply with enrollee rights and applicable State and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 468.10.

The intent of these regulations is to ensure the MAO provides appropriate information to enrollees and potential enrollees in a language and format that is easily understood. The MAO must inform enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MAO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and (438.3 (j).

The intent of these regulations is to ensure the MAO maintains P&Ps related to advance directives, including their rights under State law, and must contain clear and concise language on the limitation if the MAO cannot implement an advance directive as a matter of conscience. The MAO is responsible for providing enrollees with periodic written information regarding advance directives and their rights under the State laws. The MAO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MAO informs enrollees of their right to receive information and to receive that information in a timely manner. The MAO is responsible for ensuring enrollees have the right to participate in decisions regarding their care, to be free from any from or restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MAO provides the enrollee with information, including enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate the MMM Platino compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the MMM Platino RFI response, consisting of P&Ps, processes, workflows, and supporting documentation, including the Enrollee Handbook, Enrollee materials, contract templates, reports, letter templates, staff handbooks, provider manual, training material, training schedules, and the MMM Platino Enrollee website. This review was conducted based on information submitted by MMM Platino through the RFI and through on-site meetings held October 25, 2023. The on-site meetings involved key leadership from the MAO including, but not limited to:

- Enrollment VP
- Service Operations
- Enrollment Manager
- Customer Service Supervisor
- Operations VP
- Compliance Operations
- Enrollee Engagement Director
- Privacy Officer
- UM Director
- Network Management

Overall Assessment

Disenrollment Requirements and Limitations

MMM Platino has a strong process in place to ensure the plan is compliant with all CFR and contractual requirements pertaining to Enrollee disenrollments. There are clear written P&Ps for processing both voluntary and involuntary disenrollment requests and Enrollees have the right to file a complaint if not in agreement with the determination to disenroll. MMM Platino also has policies in place indicating the procedures and requirements for ASES to approve the disenrollment.

Enrollees are notified of their disenrollment rights which include the process for exercising disenrollment rights and the coverage alternatives available based on the Enrollee's specific circumstance. All Enrollees are notified annually of their disenrollment rights in the EOC as well as on the MMM Platino website. Disenrollment details are located in the Enrollee's Rights and Responsibilities section of the website. MMM Platino has policies in place indicating Enrollees may request disenrollment for any reason. Disenrollment will be effective on the first of the month following receipt of the written enrollment request.

MMM Platino has established procedures for notifying ASES regarding disenrollment grievances and appeals. The Compliance department is responsible for the G&A processes including communication with ASES. MMM Platino has policies ensuring Enrollees are

notified of the availability of the G&A procedures, the Administrative Hearing protocol, and process to notify ASES.

Enrollee Rights Requirements

MMM Platino also has a strong process in place to ensure compliance with all federal and Puerto Rico laws pertaining to Enrollee rights. This includes having P&Ps in place outlining all Enrollee rights which are published in the Enrollee handbook. Enrollees are advised of their rights and responsibilities upon enrollment and annually thereafter. Enrollees may request and receive a copy of their medical records and request to amend or correct their medical record as required by federal regulations.

MMM Platino has policies in place pertaining to Enrollee rights to formulate advance directives. MMM Platino provided evidence of Enrollee notification of advance directives within the Bienstar newsletter (mailed annually to Enrollees) and the EOC document. The definition of advance directives, types of advance directives, how to fill out advance directives, and important facts about advance directives can be found in Enrollee educational materials.

MMM Platino did not submit P&Ps outlining the process for moral and religious objections. Contract requirements and federal regulations requires that providers who elect not to provide, not to reimburse, or not to provide a referral or PA for a service within the scope of the detailed covered service, must notify ASES and Enrollees within a required timeframe. Following the on-site, the plan submitted a copy of the Preauthorization Process policy. The policy outlines the expectations for organizations in which they cannot reject to provide reimbursement or denied services due to religious beliefs. The Preauthorization policy did not provide reference to moral or religious objections made by a provider or provide guidance to providers on how to notify the plan, ASES and the Enrollee should a moral or religious objection occur. MMM Platino will need to develop guidance for providers regarding moral or religious objections that meet contractual and CFR requirements.

Information Requirements for Enrollees

MMM Platino complies with CFR and contractual requirements pertaining to information requirements for Enrollees. The plan has policies outlining requirements for written materials to be available in accordance with the contract standards, such as Enrollees receiving a packet of information at the time of enrollment and annually thereafter. Other required materials include the ANOC, EOC, a multi-language insert, formulary and formulary change notice requirements, an Enrollee ID card, and a provider/pharmacy directory. These documents must be provided within 10 calendar days from receipt of CMS confirmation or enrollment or by the last day of the month prior to the effective date (whichever is later). There are also policies in place indicating that Enrollees are notified in writing of changes to Enrollee materials 30 days prior to the intended effective date of these changes.

MMM Platino uses materials provided by ASES such as standardized forms, standardized notices, standardized materials, and model notices. The MAO also uses ASES models provided for ANOC, EOC, directory and formulary, enrollment and disenrollment letters, organization determinations, coverage determinations, and G&A letters to communicate with beneficiaries. If the template is not provided by ASES, MMM Platino follows ASES requirements to create the material.

ASES establishes the list of materials the plans must have available in any language that is the primary language of at least 5% of a plan benefit package service area. MMM Platino also has Enrollee information available for individuals with disabilities. MMM Platino provides auxiliary aids and services, such as alternate formats (i.e., braille, audiotapes, large print) to individuals with disabilities. The Service Operations and Sales Call Centers have available TeleTYpe (TTY)/Telecommunications Device for the Deaf (TDD) lines at no cost. The summary of benefits, ANOC/EOC, formulary, and directory inform prospective or current beneficiaries that materials are available in other formats and include instructions about how to contact the plan to request the materials in the needed format. Nondiscrimination notices and taglines are also included in the Enrollee materials. The MMM Platino website is compliant with web-based technology and information standards for people with disabilities. Materials such as enrollment forms, summary of benefits, ANOC, EOC, and directories are available to download from the website and meet federal regulation (Section 508 of the Rehabilitation Act).

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has P&P in place to ensure: (5.5.1-5.5.3) If, during the course of the Contract period, pursuant to 42 CFR 438.102, the Contractor elects not to provide, not to reimburse for, or not to provide a Referral or PA for a service within the scope of the detailed Covered Services, because of an objection on moral or religious grounds, the Contractor shall notify ASES within 120 calendar days before adopting the policy with respect to any service; Enrollees within 90 calendar days after adopting the policy with respect to any service; and Enrollees before and during Enrollment. The Contractor shall furnish information about the services it does not cover based on a moral or religious objection to ASES.	Not Met	P&Ps related to moral or religious objection were not submitted pre or post on-site review.	Develop P&Ps outlining process for moral and religious objections.

Provider Network — Access and Availability

A review of the provider network covered the following areas:

- Availability of services
- Furnishing of services and timely access
- Access and cultural considerations
- Assurances of adequate capacity and services

- Provider credentialing
- Sub-contractual relationships and delegation
- Practice guidelines

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MAO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MAO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MAO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MAO has written P&Ps for the selection and retention of providers and a documented process for the initial and recredentialing of providers. Regulation 438.214(c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214(d) prohibits the MAO from contracting with providers that are excluded from participation in Medicare and State healthcare programs.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with State requirements. The MAO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network (OON).

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MAO has P&Ps in place which guarantee the MAO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MAO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The intent of these regulations is to ensure the MAO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MAO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers, and financial considerations.

The following federal regulation is addressed in this section: 438.104.

The intent of this regulation is to ensure the MAO obtains State approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the MMM Platino organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through an on-site meeting held on October 25, 2023. The meeting involved participation from MAO key leadership including, but not limited to:

- VP, Operations
- AVP, Network Management
- AVP, Compliance Operations
- AVP, Provider Education
- AVP, Contracting
- Senior Director of Operations
- Director, Provider Network

Overall Assessment

The MMM Platino comprehensive documentation provided evidence of processes in place to meet Medicaid wrap-around service network requirements for Enrollees as required through the Platino Contract and CFR requirements. MMM Platino provided the organizational structure that is in place for network management with the Provider Network Operations Director responsible for the oversight of PNM. MMM Platino delegates contracting and credentialing to MSO of Puerto Rico, LLC which is a "sister company". The Network Excellence and Experience Unit, provides support to any internal area that needs a direct intervention with the provider. This approach not only supports the provider, but also the Enrollee.

The MMM Platino on-line Provider Directory is user friendly and includes all fields that are contractually required, these requirements include: names of physicians, specialists, hospitals, pharmacies, and BH providers, along with their provider group affiliations, locations, office hours, telephone numbers, websites, cultural and linguistic capabilities, completion of Cultural Competency training, and accommodations for people with physical disabilities and network providers that are not accepting new patients. In addition to the contractual requirements, the MMM Platino on-line directory identifies if the provider performs home visits and provides a link that Enrollees may use to request further information on the provider's credentials. Search filters are available based on language spoken, gender, ethnicity, and other (accepting new patients and handicap accessible). Enrollees are able to request a hard copy of the provider directory by calling the Enrollee services department. In addition, the Enrollee has the ability to submit information that they found to be incorrect through the on-line directory. Last, the on-line directory provides the ability for the user to increase the overall font size two times larger. The paper directory is updated monthly while the online version is updated on a daily basis.

Provider Guidelines for MMM Platino are produced by MSO and are included within the Provider Manual. The manual is a comprehensive document that educates the provider network on requirements as well as the process of MMM Platino to support the network. The Provider Manual meets the contractually required topics for inclusion and is distributed to the Provider within 15 calendar days of contracting and to Enrollees/Potential Enrollees upon request. To meet the CFR § 438.206 Availability of services requirement, the Provider Manual provides guidance on Platino coverage for family planning services and the right for Enrollees to go to a women's health specialist in their plan (such as a gynecologist) without a referral. The Enrollees Access to Specialists and other Providers policy outlines the process for OON providers. MMM Platino also provided the P&P for its Second Opinion Program, which promotes access for Enrollees to obtain a second medical opinion without additional cost, both within and outside their network. Enrollees may request a second opinion from a participating specialist for serious conditions such as cancer or neurological disorders.

MMM Platino submitted a comprehensive Cultural Competency Plan. It illustrates a holistic approach demonstrating the MMM Platino commitment to equitable and sensitive healthcare provision. The Cultural Competency Plan encompasses a range of strategies tailored to their diverse beneficiary base. It includes analyzing demographic data to understand better and serve different population groups, providing linguistic and interpreting services for non-Spanish speakers with sensitive indicators to respect various religious beliefs. The plan also emphasizes anti-discrimination policies for the LGBTQ+ population, addresses preferential turns to meet the needs of beneficiaries from island municipalities of Vieques and Culebra, and caters to the unique requirements of the elderly and disabled.

As noted, MMM Platino delegates contracting and credentialing to MSO. The documents submitted provides the process for contracting and credentialing that meets Platino contractual requirements. The process for providers to report on terminations is clear through the submitted documents, however, the documents submitted do not include the process to inform ASES on provider terminations. The Platino Contract requires that the MAO notify ASES at least 45 calendar days prior to the effective date of the suspension, termination, or withdrawal of a provider from participation in the MAO's network. If the termination was "for cause," the MAO is required to provide ASES the reasons for termination immediately and within 15 calendar days after receipt or issuance of a notice of termination to a Provider, the MAO is required to provide written notice of the termination to Enrollees who received his or her Primary Care from, or was seen on a regular basis by, the terminated Provider, and assist the Enrollee as needed in finding a new provider. MMM Platino ensures compliance and uniformity of standards across all service areas in the network.

MMM Platino submitted the provider contracts that included the fields required by the Platino contract and the Provider Termination P&P document outlines the termination processes. It specifically focuses on the methods and management of these terminations but does not address the reporting requirements to ASES or any other entities.

MMM Delegated Entity	Type of Entity and Services
MSO of Puerto Rico	Provider contracting and credentialing, network adequacy. MSO may also subcontract to other entities.

MMM Delegated Entity	Type of Entity and Services
MC-Rx (former MC-21 Inc.)	PBM Services, including contracting and management of the pharmacy network.

The following table outlines subcontractors for MSO that support Provider Network functions.

MSO Delegated Entity	Type of Entity and Services
Inspira Behavioral Care Corporation	Network functions, including credentialing
TNPR	Physical, Occupational, and Speech provider contracting and credentialing
EMPR	Contracting, credentialing, and re-credentialing of optometry providers

The MSO P&Ps submitted provides the process for contracting and credentialing that meeting the Platino requirements. All participating providers must furnish evidence of their Medicaid Management Information Systems enrollment for each practice or service location. MSO verifies the requirement using verbal, written, and internet data. MMM Platino and MSO subcontractor oversight P&Ps provide clear processes to monitor network tasks that are delegated.

The Reporting Requirements policy mandates compliance with reporting and data validation as per its contractual obligations with CMS, PRMP, and ASES. Failure to comply may result in warnings, corrective action requests, and potential sanctions such as monetary fines or contract termination. The Chief Compliance Officer oversees adherence to various documents and memoranda from CMS, PRMP, and ASES and the Compliance Department is responsible for submissions to ASES within deadlines. The Procedure for Reporting Requirements involves a structured process that includes reminders from the Compliance Officer for data submission, followed by data collection, validation, and review by the Operational Owner/SME. The Compliance Department then submits these reports and archives them, with provisions for data correction and resubmission, including adherence to CAPs when necessary, within specified timeframes.

MMM Platino is accountable for monitoring and oversight of the provider network and is performed through various methods. The Appointment Availability report includes a review of the provider address, phone number, language, acceptance of new patients, and the date of cultural training. MMM conducts quarterly reviews to monitor care access for Platino Enrollees, assessing 25% of network providers for appointment and access standards. The process involves identifying any limitations and planning corrective actions as warranted. Results are reviewed and attested by the Provider Education AVP prior to submitting to the Medicaid Compliance Department by day 20 of the following month to ensure compliance with care access for Enrollees. Additionally, a monthly report is generated for provider terminations.

To address provider recruitment and retention, MMM Platino offers reimbursement to providers that offer extended hours. MMM Platino also offers a Pay for Performance program

to urgent care providers based on outcomes for contractual PMs. The provider manual requires that Medically Necessary Services shall be available 24 hours per day, seven days per week, to the extent feasible and provides the process to monitor provider hours. The provider contracts include requirements to provide to Enrollees an adequate amount of space for services provided and disabilities treated, including waiting and reception areas, staff space, examining rooms, treatment areas, and storage.

Provider Training is in place and described through a variety of approaches. The MSO University Module and the New Providers Magazine are both documents that provide an introduction to Platino line of business. MMM provided Provider Continuing Education Curriculum for 2021 and 2022. The Provider Manual also provides guidance on the G&A process.

Number of MMM Platino Contracted Providers in 2022

Provider Type	Number of Provider Types in 2022
PCP	2,413
PMGs	25
Hospital	49
Urgent Care	76
Nursing Facility	5
Dental	1,092
Vision	1,282
BH	964
FQHC	N/A

Findings

Mercer found that the majority of the required documentation was present, MAO staff provided responses that were consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MAO staff) provided evidence of compliance with regulatory or contractual provisions. The table below provides additional documentation that is required to satisfy the contract and/or CFR requirements.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has P&P in place to report to ASES (10.5.9) at least two business days prior to taking any action against a Provider for PI reasons, including, but not limited to, denial of a Provider Credentialing/Re-Credentialing application, corrective action or limiting the ability of a Provider to participate in the program (e.g.,	Partially Met	MMM Platino provided MSO's process to monitor and terminate providers. However, the document did not include the process to inform MMM Platino or ASES.	Provide a workflow, P&P, or standard operation procedure that depicts the process to inform MMM Platino and ASES of a provider termination.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
suspending or terminating a Provider) and 7.3.1 The Contractor shall comply with all Puerto Rico and federal laws regarding Provider termination.			
The MAO has reporting P&P in place to ensure accuracy and completeness of provider credentialing, and reports are sent to ASES including termination reports: (7.3.2-7.3.3) The Contractor shall notify ASES at least 45 calendar days prior to the effective date of the suspension, termination, or withdrawal of a Provider from participation in the Contractor's network. If the termination was "for cause," the Contractor shall provide to ASES the reasons for termination immediately. Within 15 calendar days after receipt or issuance of a notice of termination to a Provider, provide written notice of the termination to Enrollees who received his or her Primary Care from, or was seen on a regular basis by, the terminated Provider, and shall assist the Enrollee as needed in finding a new Provider.	Partially Met	The Provider Termination P&Ps outline the termination processes. It specifically focuses on the methods and management of these terminations but does not address the reporting requirements to ASES. The Compliance Department is responsible for submissions to ASES within deadlines; however, documentation was not provided that included the process to track and report within the contractual requirements.	Revise the Provider Termination P&Ps to addresses the reporting requirements to ASES within the required timeframes. Develop a process to track and report within the contractual timeframes.

Coordination and Continuity of Care

A review of the coordination and continuity of care covered the following areas:

- Identification of populations with SHCN
- Enrollee monitoring for medical conditions suggesting a need for care or disease management
- Protection of Enrollee records from unauthorized disclosure per the HIPAA Privacy and Security standards

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MAO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to enrollees with SHCN, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated CC program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize QOC and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MAO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the MMM Platino organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 25, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- Quality Assurance AVP
- QM AVP
- Delegation Oversight Director
- Chief Clinical Operating Officer
- Quality Assurance Director
- UM Senior Executive Director
- Social Work Director

Overall Assessment

Mercer found all required documentation provided evidence of compliance with regulatory or contractual provisions. During the on-site review, Mercer observed MMM Platino staff provide additional material and documents, further demonstrating and confirming their compliance.

The MAO provided a comprehensive set of Coordination and Continuity of care policies. Policies included defining criteria for admission to Intensive Case Management and for Complex Case Management, privacy requirements, and standardized assessments utilized as well as the timing for assignment and assessments.

The on-site review with MMM Platino supported the MAO's RFI response and deliverables, observing staff's ability to demonstrate their knowledge and implementation of the policies and processes in place. MMM Platino provided policies outlining the process for initial engagement and assessment as well as the need for re-assessment to evaluate the continued need for case management with a daily tracking report identifying Enrollee case status and Enrollees with SHCN. MMM Platino P&Ps in place also outline the requirements for multiple attempts for engagement with Enrollees in the care coordination program. MMM Platino also illustrated P&Ps to support Enrollees transitioning from inpatient hospital stays back into the community, including stratifying Enrollees by risk and acuity, engaging the beneficiary's PCP, and engaging with care givers. Additionally, the MAO highlighted its "Access to Care" unit that supports Enrollees with accessing specialty care provider appointments by leveraging the 14 multi-clinics and telemedicine options to meet care needs.

Lastly, the MAO illustrated policy outlining the process for the Quality Department to ensure providers adhere to the Enrollee CM monitoring requirements with quarterly and ad hoc audits. Opportunities identified result in individual supervision to focus on interventions for process improvement.

Findings

MMM Platino met all requirements for these metrics through RFI documents, on-site discussions, and post on-site submissions.

UM

A review of UM covered the following areas:

- Coverage and authorization of services
- Compensation for UM activities
- Emergency and post-stabilization services
- Timeframes for authorization decisions
- Prescription drug authorization requirements
- Adverse benefit determination

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MAO, with input from providers, has clinical practice guidelines in place that reflect the needs of enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MAO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MAO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the MMM Platino organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 25, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- AVP MH Operations
- AVP Operations In patient (InHealth)
- AVP Pharmacy Services
- Chief Clinical Operations Officer
- VP Pharmacy Services
- Senior Executive Director UM
- Senior Director Pre Auth

Overall Assessment

The MMM Platino UM department provides prior authorization, concurrent and retrospective review. UM decision making, timeframes and timeliness for specified services are well defined through the UM program description and P&Ps. The UM program description is updated at least annually and is included in the QM evaluation.

MMM Platino delegates responsibilities to other agencies but retains ultimate responsibility for the UM process. The MAO has a Delegation Oversight Director (DOD) who is responsible for coordinating audits of delegated entities and presenting findings to the Delegation Oversight Committee on a quarterly basis. The DOD works closely with the compliance department to monitor performance in accordance with the agreements and support the pre-delegation audit process. The delegated entities for UM are as follows:

- MSO holdings is responsible for operations of MSO of Puerto Rico and InHealth.

  - MSO of Puerto Rico is a delegated company within MMM Platino holdings responsible for managing prior authorization, BH, CM and the pharmacy unit. PA requests are received though fax, and provider portal and reviewed against National and Local Coverage determinations and MSO Medical Policies.
  - InHealth is responsible for inpatient management including conducting concurrent and retrospective reviews, coordinating with the discharge planning unit and completing prior authorizations for transitions of care when required. InHealth utilizes a combination of MCG and Medicaid guidelines.

- The Integrated Mental Health Department (IMHD) manages BH, performing daily on-site utilization concurrent reviews within psychiatric hospitals in Puerto Rico. The review process for partial hospital programs and intensive outpatient programs are performed via telephone and fax. The IMHD uses MCG for BH reviews and the review staff are licensed nurses with experience in psychiatric nursing, licensed clinical social workers and/or clinical psychologists. The IMHD team conducts internal monitoring and are audited through the MMM Platino compliance department.
- TNPR is responsible for preservice organization determinations of therapy services. TNPR is only delegated for approvals and will refer cases back to MMM Platino for review if criteria are not met.

The MMM Platino UM staffing is based on membership, case rates, and caseloads. The staffing model consists of medical directors, operational directors, and managers (RNs), UM RNs, pharmacists, and care coordinators who are non-clinical support staff. All clinical decisions are evaluated by licensed clinical personnel and only physicians can make an adverse determination. IRR for determination making with UM staff is conducted at least annually with a required passing rate of 85%. The UM staff use MHK as the shared clinical platform. The software integrates UM history and clinical guidelines, facilitates the UM process, and provides timeline alerts. There is a referral process to facilitate integrated care and the different departments can view each other's documentation.

MMM Platino QIC is responsible for identifying levels of care that require preauthorization, developing and approving preauthorization guidelines, and monitoring under and overutilization of services within the network. The Quality Assurance and compliance team also conduct audits. The UM managers monitor compliance with timelines through pending cases reports, turnaround time reports and internal quality monitoring.

MAO staff provided responses that were consistent with the documented timeframes and notification requirements for PA services and the provision of authorization of emergency and post stabilization services.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has written P&Ps that: (i) identify, define, and specify the amount, duration, and scope	Partially Met	MMM Platino does not have a formal P&P in place to ensure the PA	Submit a P&Ps that outlines the MAO's process to

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
of covered services available under the contract and how and where to access such services; (42 C.F.R. § 438.10. Platino section 4.3.1.2) The MAO has P&Ps to ensure its PA requirements comply with the requirements for parity in MH and SUD benefits under 42 C.F.R.§ 438.910(d) (Platino 5.3.9.2)		requirements are following the requirements for parity in MH and SUD benefits. MMM reports that they do not restrict any BH services and use the same criteria (MCG) and no PA is needed for BH services and concurrent review processes are the same.	ensure authorization requirements comply with parity requirements.
The MAO has written P&Ps that prohibit the MAO or any delegated UM agent from providing compensation or anything of value to its employees, Agents, or contractors based on: either a percentage of the amount by which a claim is reduced for the payment or the number of claims or the cost of services for the denied authorization or payment; or any other method that encourages a decision to deny, limit, or discontinue a Medically Necessary covered service to any Enrollee. (Platino 8.2.4) (42 C.F.R. § 438.210€)	Partially Met	The MMM Platino UM Program Description includes a Financial Compensation Disclosure that states utilization decisions are not incentivized in any way; however, this is not detailed in any submitted policy.	Revise UM P&Ps to include prohibiting the MAO or any delegated UM agent from incentivizing UM decisions.

G&A

A review of G&A covered the following areas:

- General grievance system requirements, including:
  - Information about the grievance systems shared with providers and subcontractors
  - Grievance system P&Ps
  - Authority to file
  - Handling of G&A
  - Recordkeeping requirements

- Grievance system management, including the grievance process and resolution, and notification
- Appeals process management, including the appeals process and resolution, and notification

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MAO has in effect a grievance and appeal system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MAO must inform members of how to access the grievance system, the availability of the MAO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MAO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MAO provides notice of adverse benefit determinations letters that are compliant with language, content, and format as required by enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MAO provides enrollees with assistance, if requested, to complete processes within the grievance system. The MAO has processes in place ensuring enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MAO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MAO must keep a log of all G&As filed. The MAO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate the MMM Platino compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the MMM Platino RFI response and supporting documentation including P&Ps, Enrollee Handbook, the MMM Platino Enrollee website, G&A department structure, and program highlights. This review was conducted based on information submitted by MMM through the RFI and through on-site meetings held on October 25, 2023. The on-site meetings involved key leadership from the MAO including but not limited to:

- AVP, Compliance Regulatory
- Director, G&A
- Manager, G&A
- Lawyer, Medicaid

Overall Assessment

The grievance system follows standard processes. Complaints, grievances, and appeals can be received from Enrollees, Enrollee representatives, or providers verbally through Customer Services call center or in-person at a service center, or be written (i.e., filling out a form on the MMM Platino website and submitting it, fax, or mail). If a grievance is received verbally, the Customer Service Representative documents the grievance in Onbase and routed to the G&A department. Onbase is used as a repository and tracking system for all Enrollee complaints and grievances received via Enrollee Services and the Service Centers and is used for reporting.

Grievance staff facilitate the grievance investigation, producing and sending Enrollee notification letters, and coordinating investigations with other impacted business units. For example, the PNM team will be sent quality of service grievances; a QOC grievance is sent to the Quality team. Onbase is used for tracking the timeliness of resolution and housing all grievance documentation. Grievance acknowledgement letters are sent within 10 business days and resolution letters within 30 calendar days of receipt of the grievance.

Enrollee complaints are received, documented, and resolved by Customer Service at the time of the initial call. Once entered in the Onbase system, complaints are routed to the G&A department. The MAO differentiates complaints and grievances depending on whether resolution was achieved during the initial Enrollee interaction. Complaints data is aggregated with grievance data and shared with appropriate operational areas to identify continuous

improvement opportunities. It should be noted that during the on-site interview, MAO staff were unsure how complaints were managed or how the data was used. Follow-up information was provided that explained the complaints management process. There is an opportunity for the MAO to provide training to any staff who support the complaints and grievance process to ensure consistency of understanding across the organization.

Similar to grievances, standard appeals are accepted both verbally (through Enrollee Services) or in writing (appeals form can be found on the MAO's website) and sent to MMM Platino via US mail, fax, or Enrollee portal. Verbal appeals filed by providers are required to have written Enrollee consent. The appeal start date is the date the initial appeal is received. The MMM Platino G&A policy indicates that appeals may be filed verbally; however, it also contains language that indicates a written signed appeal must be received. The MAO explained during the on-site interview that verbal appeals do not need to be followed-up with a written appeal for the Medicaid population. There is an opportunity for the MAO to review their P&Ps and provide training to MAO staff on any changes to ensure there is no confusion between Medicare and Medicaid requirements.

Appeals staff are responsible for sending out Enrollee correspondence including the initial acknowledgement letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuity of care is requested in the appeal, the analyst checks to ensure the proper steps have occurred and timelines are met. The Enrollee or Enrollee representative has the opportunity to present the case and answer any questions. The case is reviewed by the Medical Director, and a decision is issued and communicated to the Enrollee verbally and written. If the case is overturned, the G&A analyst enters into MHK to generate the approval notice for Enrollee and provider. In 2022, nearly 84% of adjudicated appeals were overturned in full or in part. There is an opportunity for MMM Platino to review the PA process to reduce burden on the Enrollee. The determination is updated in Onbase to create the authorization. In the case of an upheld appeal decision, the case file is automatically forwarded to the independent review entity for review and determination. The Enrollee appeal resolution letter provides information on steps to request an ALH.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has a written grievance system under which Enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, Covered Services. The Grievance System includes a Complaint process, Grievance process, Appeal process, and access to the ALH process. (42 CFR part 422 Subpart M) (42 CFR	Partially Met.	Enrollee complaints are managed in Enrollee Services department rather than as an integrated component of the G&A System. (11.1.2)	Develop P&Ps to support contract requirements outlined in Article 11 including appropriate definitions for and tracking and trending of complaint, grievance, and appeals data.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
Part 438, Subpart F) Platino Article 11.1; 11.1.2.			
The MAO's Grievance System P&Ps include at a minimum: Process and timelines for filing a Complaint, Grievance, Service Authorization request or Appeal, or seeking an ALH; Process for receiving, recording, tracking, reviewing, reporting, and resolving Grievances, Service Authorization Requests and Appeals filed verbally, in writing, or in-person; Process and timeframe for Enrollee's authorized representative or Provider to file a standard or expedited complaint, grievance service authorization or appeal on behalf of Enrollee; Process for notifying Enrollees of their right to file a Complaint, Grievance, or Appeal with the Patient Advocate Office and how to contact the Patient Advocate Office; Procedures for the exchange of information with providers, ASES, and Enrollees regarding Complaints, Grievances, Service Authorizations and Appeals; Process and timeframes for notifying Enrollees in writing regarding receipt, resolution, and other action related to, Complaints, Grievances,	Not Met.	The MAO's policies do not include a process to ensure written Notices of Adverse Benefit Determination to Enrollees meet the language and format requirements and be set in accordance with the timeframes described in the Platino Contract. The MAO does not have a clear process for collecting and analyzing the G&A system data (including complaints data) for inclusion in the plan's quality strategy. (42 CFR § 438.402, 42 CFR § 438.10) (Platino 11.1.5)	Develop P&Ps that describe how the MAO ensures that Enrollee materials meet the requirements in section 4.2 and 4.3 and include all elements identified in Article 11 of the Platino Contract.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
Service authorizations and Appeals. Including requirements governing the delay of reviews and extension requests as well as denial of request for expedited review. (Platino 11.1.5)			
The MAO's policies, procedures, Enrollee Handbook, and Provider Manual clearly explain that an Enrollee, Enrollee's Authorized Representative, or Provider (with Enrollee's written consent) may file a Complaint, Grievance, service authorization request, Appeal, or request an Administrative Law Review verbally or in writing with the MAO or with the Office of the Patient Advocate of Puerto Rico. (42 CFR §438.402(c)(3)) (Platino 11.1.5.3; 11.1.8; 11.1.11)	Partially Met.	The MAO's Provider Guidelines manual does not include all elements identified in the Platino contract.	Revise the Provider Guidelines to include all elements outlined in the Platino Contract.
The MAO's P&Ps, Enrollee Handbook, and Provider Manual clearly state that a grievance may be filed at any time and that the MAO will acknowledge receipt of each grievance in writing within 10 business days of receiving the grievance. (Platino 11.3.1-3 and 11.5) (42 CFR §438.402.(2)(i))	Not Met.	The MAO's P&Ps and Provider Manual do not clearly state that the MAO will acknowledge receipt of each grievance in writing within 10 business days of receiving the grievance. (42 CFR §438.402.(2)(i)) (11.1.5.6) (11.3.3)	Revise Enrollee and provider materials to include information on how and when the Enrollee will receive an acknowledgement following receipt of a grievance.
The MAO's P&Ps, Enrollee Handbook, and Provider Manual clearly state that an Enrollee may file an appeal verbally or in writing within 60 Calendar Days after receiving an Adverse Benefit Determination and will	Not Met.	The MAO's Provider Guidelines and policy do not specify that an Enrollee can file an appeal verbally without a written follow-up or the timeline to receive an acknowledgement of	Revise the Provider Guidelines and P&Ps to include all elements outlined in the Platino Contract.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
acknowledge receipt of the appeal. The contractor shall acknowledge receipt of each appeal in writing within 10 business Days. (42 CFR §438.402 (2)(ii)) (Platino 11.5.4 and 11.5.6).		their appeal. (11.1.5) (11.1.11)	
The MAO's P&Ps clearly state time frames for standard resolution of appeals and notification of the decision within 30 calendar days. (42 C.F.R. §438.408) Written Notice of Disposition of an appeal is provided to the Enrollee ASES within two Business Days of the decision. (11.5.10.1 and 11.5.13)	Partially Met.	MMM Platino does not have a process in place to notify ASES of appeal outcomes. (11.5.13)	Develop P&Ps to notify ASES of appeals outcomes within two business days of decision.

QAPI Program

A review of the QAPI program includes the following:

- The presence of an ongoing comprehensive QAPI program
- Monitoring and assessment of the QAPI
- Analysis and reporting of the QAPI
- Performance measurement
- QI initiatives

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MAO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to , utilization, claims, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330.

The intent of this regulation is to ensure the MAO has an ongoing quality assessment and performance improvement program for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with SHCN.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the MMM Platino organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 25, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- Clinical Quality Manager
- QM Director
- AVP of QM
- VP of QM and Stars
- Compliance Audit Specialist

Overall Assessment

The Mercer assessment found all required documentation provided evidence of compliance with regulatory or contractual provision. During the on-site review, Mercer observed the MAO staff provided responses that were consistent with each other and with the submitted documentation.

MMM Platino illustrated a comprehensive QAPI program with a diverse SME team and multiple quality focused committees responsible for monitoring and analyzing quality reporting as well as the production of the annual QAPI evaluation. Additionally, the MAO demonstrated in its P&Ps the approach for ongoing data collection, monitoring, evaluating, and reporting of quality indicators and metrics, including HEDIS and CAHPS outcomes. MMM Platino presented comprehensive processes for developing and implementing strategies to ensure the delivery of accessible, timely, and medically necessary services, including their process to ensure that the covered services provided to the Enrollees meet the optimal clinical standard. Within these processes, the MAO also outlined its approach to integrate UM trends within the QIC for focused improvement plans. MMM Platino also highlighted in their response that one of the goals for the QAPI program is to achieve accreditation.

Lastly, MMM Platino provided a clear description of the process for multiple systems providing data that funnels into an internal data warehouse. This data warehouse includes a process for extracting for the HEDIS vendor platform, resulting in the quality reports monitored by the QAPI program and QIC.

Findings

MMM Platino met all requirements for these metrics through RFI documents, on-site discussions, and post on-site submissions.

Triple S Platino

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Humana's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 26, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- CEO
- Directors
- Leads
- Supervisors
- Senior Nurses
- Compliance Officers
- Program Managers
- Auditors

Strengths

The Triple S Platino team presented with strong leadership and passion for their Enrollees, showing engagement and willingness to participate in on-site discussions which provided additional detail to abiding by the Code of Federal Regulations and the Platino contract.

Triple S Platino has P&Ps in place to educate their Enrollees on how to exercise these rights related to Advance Directives. Additionally, Triple S Platino has embedded a knowledge question into the HRA where care managers evaluate and document Enrollee's knowledge of advanced directives. This process allows Triple S Platino staff to quickly identify if a lack of knowledge on advanced directives exists and take action with an educational intervention.

Opportunities for Improvement

There is an opportunity for Triple S Platino to review and revise or develop P&Ps to ensure all federal and contractual requirements are followed.

There is an opportunity for Triple S Platino to review and revise provider contracts to articulate an Enrollees option to obtain a second opinion, in- or- OON, at no cost to the Enrollee.

There is an opportunity for Triple S Platino to ensure interdepartmental collaboration between CM and Provider Network teams to ensure Provider compliance as well as monitor the need for additional outreach or training for providers regarding CM and Disease Management referrals.

Recommendations

Review and revise available P&Ps to ensure regulatory and contractual compliance. Provide training to staff on newly developed and revised P&Ps.

Update provider contracts and P&Ps to align with CFR § 438.206, to show that second opinion coverage is offered at no cost to the Enrollee in- or- OON.

Revise P&Ps to include development for oversight responsibilities with monitoring provider compliance with CM and Disease Management requirements. Provide training to staff on revised P&Ps.

Administration and Organization

Overview

Organizational Structure

Triple S Advantage (TSA or Triple S Platino) is a subsidiary of Triple S Management Corporation which offers commercial, federal, Medicaid and Medicare Advantage lines of business in Puerto Rico. The Platino organizational structure falls under an Executive Affairs Administrator who reports directly to the CEO. This administrator oversees the President of Triple S Platino, and numerous C-suite executives. The organizational structure of Triple S Platino appears to share key positions with other Triple S lines of business.

The COO oversees UM (including preauthorization and facility-based CM), health management, contracting and administration, service administration (including call centers), innovation and integration, and provider relationships and partnerships. The Chief Strategy Officer manages contracting and administration, clinic networks, provider relationships and partnerships, healthcare service and quality integration, and population health management. The CMO oversees medical quality, integrated delivery system, pharmacy, G&A, HEDIS and Stars, and the Quality Improvement Medical Director.

Delegated Entities

Triple S Platino delegates responsibilities to ten different entities outlined in the table below.

Delegated Entity	Type of Entity and Services
Abarca (PBM)	Pharmacy benefit management.
APS Healthcare of Puerto Rico	MH Services — MH benefits, MH provider network credentialing and recredentialing, MH claims and processing and payment, pharmacy services, MH quality and UM services, BH CM, MH and pharmacy G&A, MH education, reporting, MH Enrollee, and provider call center.

Delegated Entity	Type of Entity and Services
Clinical Medical Services	Durable Medical Equipment (DME) UM approvals.
LinkActiv	Call Center Services — for providers and beneficiaries and reporting.
Medical Advice Line	24-hour emergency medical advice toll free line.
Oncology Analytics (dba OncoHealth)	Oncology-related UM approvals.
Optum	Claims processing, IT.
Pager and Beeper Medical Group	Nursing advice line.
Telemedik	PSG call center Medicaid.
TNPR — also known as HN1	Physical, occupational, and speech language therapy UM approvals.

Triple S Platino has P&Ps in place which operationalize the monitoring, oversight, and auditing of delegated entities. Oversight of delegated entities fall under the Triple S Platino compliance and privacy office.

Accreditation

Plan Accreditation is not a contractual requirement. Triple S Platino did not report any accreditations during this report period.

Employee Training

The MAO requires all newly hired employees to complete a training curriculum through a Learning Management System which includes topics such as a Review of the Triple S Platino Compliance Program, Advance Directives, Cultural Competency, FWA, Elderly Financial Exploitation, Code of Business Conduct and Ethics, HIPAA, and a Medicaid Overview. Customer Services and G&A staff are required to also complete a training on G&A. Delegated entities must take trainings covering FWA, HIPAA, Code of Business Conduct and Ethics and a Medicaid overview. The UM delegated entities also participate in IRR training. All staff must complete these trainings annually thereafter. Triple S Platino utilizes a variety of formats to train employees, including online trainings, in-person class trainings and written educational materials.

Enrollee Rights and Protections

A review of Enrollee rights and protections covered the following areas:

- Disenrollment requirements and limitations
- Enrollee rights requirements, including Enrollee rights and responsibilities, advance directives, the right to receive information, and moral and religious objections
- Information requirements for Enrollees

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MAO complies with the State enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MAO has written policies related to Enrollee rights and ensure the MAO complies and holds staff and affiliated providers accountable to comply with Enrollee rights and applicable State and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and438.10.

The intent of these regulations is to ensure the MAO provides appropriate information to Enrollees and potential Enrollees in a language and format that is easily understood. The MAO must inform Enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific Enrollee rights and protections is identified and communicated to Enrollees, staff, and providers acting on behalf of the MAO, including Enrollee's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (j).

The intent of these regulations is to ensure the MAO maintains P&Ps related to advance directives, including their rights under State law, and must contain clear and concise language on the limitation if the MAO cannot implement an advance directive as a matter of conscience. The MAO is responsible for providing Enrollees with periodic written information regarding advance directives and their rights under the State laws. The MAO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MAO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MAO is responsible for ensuring enrollees have the right to participate in decisions regarding their care, to be free from any from or restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MAO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to Enrollee benefits, provider terminations, limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate the Triple S Platino compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the MAO's RFI response, consisting of P&Ps, processes, guidelines, workflows, and supporting documentation, including the Enrollee Handbook, Enrollee materials, monitoring templates, reports, letter templates, staff handbooks, training material, training schedules, and the Triple S Platino Enrollee website.

This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 26, 2023. The on-site meetings involved key leadership from the MAO including, but not limited to:

- Compliance Auditor
- Customer Service Manager
- Reconciliation Regulatory Coordinator
- Federal Programs Supervisor
- Production Development Manager
- Enrollment Director
- Call Center
- Compliance Services Unit
- Care Manger Senior Nurse
- Enrollment Manager
- Assistant Marketing Manager
- G&A Supervisor

Overall Assessment

Disenrollment Requirements and Limitations

Triple S Platino has a process in place to ensure the plan is compliant with all CFR and contractual requirements pertaining to Enrollee disenrollments. There are clear written P&Ps for processing both voluntary and involuntary disenrollment requests in accordance with the enrollment and disenrollment state and federal guidance. Disenrollment information for Enrollees and their rights pertaining to disenrollment can be found in the disenrollment policies and the EOC. The EOC (Chapter 10) covers processes for ending both voluntary and involuntary Membership with the plan. Triple S Platino also sends disenrollment letters to Enrollees depending on their specific circumstance. Examples of disenrollment letters include the Notice to Confirm Voluntary Disenrollment letter which is sent following receipt of daily transaction reply report and the Notice to Acknowledge Receipt of Voluntary Disenrollment Request by Enrollee. Triple S Platino has P&Ps in place which reflect that disenrollment occurs only as directed by ASES.

Triple S Platino has established procedures in place to ensure grievances are processed and resolved in accordance with CFR regulations and contractual requirements. The plan establishes and maintains procedures for resolving both standard and expedited grievances between Enrollees and the Medicare health plan or any other entity or individual through which the Medicare health plan provides healthcare services. Triple S provides written information to Enrollees or their representatives regarding grievance procedures. Grievance information is available through initial enrollment, upon involuntary disenrollment initiated by

the plan, upon denial of an Enrollee's request for expedited review of an organization determination or appeal, upon an Enrollee's request, and annually.

Enrollee Rights Requirements

Triple S Platino also has a strong process in place to ensure compliance with all federal and Puerto Rico laws pertaining to Enrollee rights. This includes having P&Ps in place outlining all Enrollee rights which are published in the EOC. Enrollees are advised of their rights and responsibilities upon enrollment and annually thereafter. Enrollees may request and receive a copy of their medical records and request to amend or correct their medical record as required by federal regulations.

Triple S Platino meets federal regulation and contract requirements for notification of Enrollees regarding their rights to formulate advance directives. Triple S Platino has P&Ps in place related to advance directives and educates their Enrollees on how to exercise this right in the EOC upon enrollment and annually. Through the CM Program, a question on knowledge of Enrollee advanced directives is embedded into the HRA. Care managers evaluate and document Enrollee's knowledge of advanced directives. If a lack of knowledge on advanced directives is identified, an educational intervention is performed. The care manager can arrange a social worker or nursing intervention and/or visit if the need for additional information and/or assistance in completing the Health Care Proxy is identified. After the visit, the social worker or nursing representative contacts the care manager to inform him/her of the patient's decision regarding their advanced directives/Health Care Proxy. Furthermore, an appointment can be coordinated with the PCP to assist with completing the corresponding documentation. The Enrollee Handbook outlines Enrollee rights to file complaints concerning non-compliance with advanced directives requirements directly with ASES or with the Puerto Rico Office of the Patient Advocate.

Triple S Platino does not have P&Ps outlining the process for moral and religious objections. Contract requirements and federal regulations requires that providers who elect not to provide, not to reimburse, or not to provide a referral or PA for a service within the scope of the detailed covered service, must notify ASES and Enrollees within a required timeframe. Following the on-site, the plan submitted a copy of the Enrollees right and Responsibilities policy. The policy outlines the expectations for Enrollees in which they have the right to refuse treatment and to express preferences about future treatment decisions, including objections due to moral or religious beliefs. This policy did not provide reference to moral or religious objections made by a provider or provide guidance to providers on how to notify the plan, ASES and the Enrollee should a moral or religious objection occur. Triple S Platino will need to develop guidance for providers regarding moral or religious objections that meet contractual and CFR requirements.

Information Requirements for Enrollees

Triple S Platino complies with CFR and contractual requirements pertaining to information requirements for Enrollees. Written materials are available in alternative formats and in a manner that takes into consideration special needs, including Enrollees who are visually impaired or have limited reading proficiency. Triple S Platino addresses health literacy by using plain and simple language in marketing materials. Marketing materials are worded at the fourth-grade level per contract requirements. Assessment of health literacy and plain language in marketing materials is performed using the Microsoft Word add-in "Health

Literacy Advisor", a platform used to monitor readability scores. The compliance analyst is responsible for completing the material marketing review checklist form which includes necessary information for validation as required by regulation and ASES, such as disclaimers and font size.

Verbal interpretation services, written materials in other languages, and TTY/TDD are available for Enrollees. Verbal interpretation requirements apply to all languages and not just those identified by the Government of Puerto Rico as predominant. Interpreter services must be provided at the time the Enrollee is identified as speaking a foreign language or when requested. Interpreters are available within eight minutes of making contact. The customer service representative communicates with the contracted translation service and coordinates a conference call between the Enrollee, the interpreter, and the customer service representative. Enrollees are instructed to contact Enrollee services for all alternate format information and requests.

Enrollees receive the EOC booklet at the time of enrollment. Procedures for Enrollee notifications are the responsibility of the product development department. The plan has P&Ps in place for notifying Enrollees of changes annually.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has P&Ps in place to ensure: (5.5.1-5.5.3) If, during the course of the Contract period, pursuant to 42 CFR 438.102, the Contractor elects not to provide, not to reimburse for, or not to provide a Referral or PA for a service within the scope of the detailed Covered Services, because of an objection on moral or religious grounds, the Contractor shall notify ASES within 120 Calendar Days before adopting the policy with respect to any service; Enrollees within 90 Calendar Days after adopting the policy with respect to any service; and Enrollees before and during Enrollment. The Contractor shall furnish information about the services it does	Not Met.	Triple S Platino does not have P&Ps or guidance in place for providers pertaining to moral or religious objections.	Develop clear P&Ps and guidance to providers regarding notification requirements to the plan, ASES and Enrollees when providers issue a moral or religious objection.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
not cover based on a moral or religious objection to ASES.			

Provider Network — Access and Availability

A review of the provider network covered the following areas:

- Availability of services
- Furnishing of services and timely access
- Access and cultural considerations
- Assurances of adequate capacity and services
- Provider credentialing
- Sub-contractual relationships and delegation
- Practice guidelines

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MAO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MAO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MAO's Enrollee demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MAO has written P&Ps for the selection and retention of providers and a documented process for the initial and recredentialing of providers. Regulation 438.214(c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost Enrollees. 438.214(d) prohibits the MAO from contracting with providers that are excluded from participation in Medicare and State health care programs.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with State requirements. The MAO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network (OON).

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MAO has P&Ps in place which guarantee the MAO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MAO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The intent of these regulations is to ensure the MAO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MAO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers, and financial considerations.

The following federal regulation is addressed in this section: 438.104.

The intent of this regulation is to ensure the MAO obtains State approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the Triple S Platino organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through an on-site meeting held on October 26, 2023. The on-site meeting involved participation from MAO key leadership including, but not limited to:

- Senior Manager Contracting and Administration
- Credentialing Director
- Provider Operations Director
- Vendor Management Contract Administrator
- Compliance Regulatory Lead
- Compliance Auditor
- Federal Compliance Officer

Overall Assessment

Triple S Platino provided comprehensive documentation regarding their Medicaid service network. Mercer found most Platino Model Contract and CFR requirements were

documented in the materials submitted for the desk review. Staff provided consistent responses during the on-site and submitted the requested follow-up documents on time. The follow-up documents submitted provided evidence of contractual provisions in all but two areas.

Triple S Platino presented with strong leadership and passion for their Enrollees. They consistently monitor the network to ensure access is readily available for Enrollees. The user-friendly online provider directory covers provider capacity, cultural competency, handicap accessibility, languages spoken, affiliations, and hours of operation. The MAO keeps a thorough review and reporting process in place, ensuring that the network has a sufficient array of providers, and that providers meet timely access requirements, maintain required hours of operation, and offer accessible physical locations and accommodations when needed. Triple S Platino provided site visit reports verifying the inspection of physical accessibility.

Triple S Platino provided EOC for the required areas of women's health specialist for routine and preventive healthcare services, and adequate and timely access and coverage for Network Providers as well as OON services if Contractor is unable to provide such access. The policies submitted did not cover the ability to obtain a second opinion, in- or OON, at no cost to the Enrollee.

Triple S Platino maintains a large network of providers and subcontractors. They use Medicare Enrollee numbers as the base for the number of needed providers, knowing there are fewer Medicaid Enrollees than there are for Medicare. Triple S Platino provided policies covering that providers must be Medicaid enrolled. They also provided verification that provider contracts cover all required details regarding obligations and covered services.

Triple S Platino has a Participating Providers Relations Program which includes provider orientation, with ongoing education and support provided virtually as well as in person. Providers are also trained on the G&A process during orientation.

Delegation agreements were submitted, verifying the oversight of delegated entities by the delegation department. The following table outlines the subcontractors that support Provider Network functions.

Delegated Entity	Type of Entity and Services
Abarca (PBM)	PBM
APS Healthcare of Puerto Rico	BH Services — network management activities, including contracting and credentialing
LinkActiv	Call Center Services — for providers and beneficiaries and reporting
TNPR — also known as HN1	Physical, Occupational, and Speech Services — provider contracting and credentialing

Triple S Platino has a detailed credentialing and re-credentialing process as evidenced through the materials reviewed during the desk review. They also submitted policies regarding provider termination, and the follow-up documents clarified the communication to ASES part of the process, which occurs through the Compliance Department.

Triple S Platino provided a comprehensive Cultural Competency Plan as part of the follow-up documents. The plan lays out the requirements for providers to ensure Enrollees are treated without discrimination and that providers receive regular training on cultural competency areas. The plan does not clarify how and when it is distributed to providers or that it has been approved by ASES.

Number of Triple S Platino Contracted Providers in 2022

Provider Type	Number of Provider Types in 2022
PCP	2,218
PMG	9
Hospital	50
Hospital Psychiatric	1
Urgent Care	63
Nursing Facility	3
Dental	993
Vision	107
BH	1,047
Other	6,907

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has P&Ps in place aligning with:(42 C.F.R. § 438.206) (42 CFR 438.207(c)) (6.1.1- 6.1.2) establish and maintain a network of Network Providers that complies with 42 CFR 438.206(b)(l) and is otherwise sufficient to provide adequate access to covered services to meet the needs of Enrollees in the Medicare Platino Plan. This must include a women's health specialist to provide women's routine and preventive healthcare services, ability to obtain a second opinion, in- or- OON, at no cost to the Enrollee. Adequate and timely access and coverage for Network Providers as well as	Partially Met.	The submitted contract states the right to a second opinion is at their own expense with a contracted provider, however CFR § 438.206 states it should be at no cost, both in- and OON.	Update provider contracts and P&Ps to align with CFR § 438.206, to show that second opinion coverage is offered at no cost to the Enrollee in- or- OON

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
OON services if Contractor is unable to provide such access.			
MAOs have P&Ps in place to (7.2.1.29) Require that the Provider comply with the Contractor's Cultural Competency plan; (4.5.1) (42 CFR 438.206), have a comprehensive written Cultural Competency plan describing how the Contractor will ensure that services are provided in a culturally competent manner to all Enrollees.	Partially Met.	Triple S Platino submitted the Cultural Competency Plan but it does not state that it is distributed to the providers and approved by ASES as required by the Platino contract.	Update the Cultural Competency Plan to show verification of ASES approval and how the plan is distributed to providers.

Coordination and Continuity of Care

A review of the coordination and continuity of care covered the following areas:

- Identification of populations with SHCN
- Enrollee monitoring for medical conditions suggesting a need for care or disease management
- Protection of Enrollee records from unauthorized disclosure per the HIPAA Privacy and Security standards

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MAO has procedures to deliver primary care appropriate to an Enrollee's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to Enrollees with special health care needs, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated CC program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both Enrollees and providers to optimize QOC and Enrollee health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MAO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MCS' organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 26, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- Health Management Program Director
- Privacy Officer
- Compliance Auditor
- Population Health Management Auditor
- Analyst

Overall Assessment

Mercer found Triple S Platino documentation providing evidence of compliance for some, but not all of the regulatory or contractual provisions.

The MAO policy illustrated processes for enhanced CM for individuals with HCHN, Chronic and Complex Conditions, Special Coverage Needs, High Utilizers, and Enrollees that may require intensive assistance. The policies also include an outline of priority stratifications levels and methods of Enrollee identification for CM. Triple S Platino policy illustrated requirements for three phone attempts on different dates and times, followed by a mailed letter to Enrollee. The policy further states that when a physical address is available, the MAO staff attempt a face-to-face outreach. Triple S Platino policy also includes requirements for a HRA completion, used to determine needs, completed within 90 days for new Enrollees, 60 days for high utilizers from date case is opened, and for direct referrals the HRA is completed within 30 days of the referral.

Additionally, Triple S Platino policy illustrates the process within the care coordination system that flags cases based on claims activity that need follow-up by the care manager. The system supports risk stratification of Enrollees and will prompt care managers to regularly update HRAs to identify potential changes in risk stratification. Triple S Platino staff also provided P&Ps detailing the protections in place for PHI preventing unauthorized disclosure and ensures that the handling of PHI aligns with HIPAA Privacy and Security Standards.

Per 42 CFR § 438.208(c)(4), for Enrollees with SHCN requiring a course of treatment or regular care monitoring, the health plan must have a mechanism in place to allow Enrollees

to directly access a specialist as appropriate. Triple S Platino provided evidence of policy stating care managers assist with referrals to specialists and sub-specialists as needed. During the on-site review, Mercer observed Triple S Platino staff describe and verify the existence of compliant practices for referrals and linkages during the interview. However, staff also recognize they do not have a policy documented to support their compliance with linking Enrollees to specialists or sub-specialists when a referral is indicated. The MAO did submit a policy describing its OON and emergency services provider availability as result of the on-site review, but upon review the policy was limited to OON and the mechanisms to assure Enrollees have access to medically necessary covered healthcare services through OON providers. The policy did not clarify the CM team's process with linking Enrollees to specialists or sub-specialists (in- or- OON) when a referral is indicated.

Lastly, during the on-site review, Triple S Platino staff provided a description outlining their process to monitor CM referrals by providers to ensure quality, however, also stated that the team does not have a policy within CM to ensure provider adherence to requirements for monitoring Enrollees with a medical condition that could benefit from CM and Disease Management. Triple S Platino staff referenced their Network/Provider teams as a possible role in this oversight. It was noted during on-site, the Mercer review team and the MAO CM staff agreed with the value of interdepartmental collaboration with Triple S Platino Network/Provider teams to monitor the not only for compliance but also the need for additional outreach or training for providers regarding CM and Disease Management referrals. The MAO staff submitted additional documentation titled "MD Referral Process to Care Management", created November 2, 2023, in response to this finding. The policy outlined the process for provider referrals received by Care Managers and a workflow that detailed how the email referrals are processed; however, it did not clearly indicate the process for oversight of provider adherence to requirements for monitoring Enrollees that could benefit from CM.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has P&Ps for the identification of populations with SHCN in order to identify any ongoing special conditions that require a treatment plan and regular care monitoring by appropriate Providers. (Appendix C5), (6.1.2.7), (42 CFR § 438.208(c)(4)).	Partially Met.	Triple S Platino staff described the approach for linking Enrollees to specialists or sub-specialists and working with the PNM to resolve specialist access issues. The process may also include the utilization of an "OON" provider via the use of a "letter of agreement". It can take about an average of two to three weeks to resolve an access to provider issue. Triple S Platino stated that	Develop written P&Ps to formalize the approach to linking Enrollees to specialists or sub-specialists when a referral is indicated, including the escalation process and timeframe requirements.

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
		there is no policy to document the process and direction at this time.	
The MAO provider contracts include requirement for providers to monitor Enrollees to determine whether they have a medical condition that suggests CM or Disease Management services are warranted. (7.2.1.19)	Partially Met.	Oversight Policy for provider adherence to CM and Disease Management requirements was not provided. The policy outlined the process for provider referrals received by Care Managers and a workflow that detailed how the email referrals are processed, however the policy did not provide details regarding how Triple S Platino ensures provider adherence to requirements for monitoring Enrollees with a medical condition that could benefit from CM /Disease Management.	Revise P&Ps to include development for oversight responsibilities with monitoring provider compliance with CM and Disease Management requirements.

UM

A review of UM covered the following areas:

- Coverage and authorization of services
- Compensation for UM activities
- Emergency and post-stabilization services
- Timeframes for authorization decisions
- Prescription drug authorization requirements
- Adverse benefit determination

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MAO, with input from providers, has clinical practice guidelines in place that reflect the needs of Enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to Enrollees are clearly identified and that the MAO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the Enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MAO assists the Enrollee to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Triple S Platino 's organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 26, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- Pre-Authorization Director
- UM Manager
- FBCM Director
- Senior Compliance Auditor
- Pharmacy Compliance Officer
- Pharmacy Manager
- Compliance Auditor

Overall Assessment

The Triple S Platino UM department provides prior authorization, hospital based concurrent review at 56 contracted facilities and retrospective review of hospital admissions. The services requiring PA and concurrent review are clearly defined. UM decision making, timeframes and timeliness for specified services are well defined through the UM program description and P&Ps. The UM program description is updated at least annually and is included in the QM evaluation.

Triple S Platino has a UM committee that meets on a quarterly basis. The committee reviews the utilization activities, including any findings, and recommendations, the over and underutilization metrics, G&A data and referrals to CM and the SIU.

Triple S Platino reports that UM staffing is stable currently without challenges, UM staff are assigned to PA and hospital-based roles. All staff are dedicated to and reside within Puerto

Rico. The PA teams are separate for Platino and Plan Vital Enrollees, while the on-site hospital-based teams will provide services for Enrollees in all lines of business. The on-site registered nurses support the transition process, coordinate with the social worker, and make referrals to CM when indicated. The staffing model consists of clinical staff and non-clinical staff. All clinical decisions are evaluated by licensed clinical personnel and only physicians can make an adverse determination.

The Triple S Platino supervisors monitor the caseloads and timelines of the PA unit at least three times a day. Admission reports are received daily and are used to assign staffing based on census at 56 contracted facilities. Targeted quality case reviews are conducted as well as routine formal auditing for all teams.

Triple S Platino and APS use InterQual as its evidence based clinical guidelines and for oncology services, NCCN guidelines are utilized. IRR is conducted at least annually via InterQual with a required passing rate of 80%.

Triple S Platino utilizes four delegated entities as part of the UM operations. The compliance department is responsible for training and monitoring the performance through its Delegated Oversight Department. APS is fully delegated to manage BH UM including prior authorization, clinical concurrent reviews, discharge planning, medical necessity review, physician consultation and handling appeals. APS is able to access the Triple S Platino system and provides monthly and quarterly reports as well as case discussion to coordinate care. The other three entities are delegated for preservice organization determinations only approvals and will refer cases back to Triple S Platino for review if criteria are not met.

Delegated Entity	Type of Entity and Services
OncoHealth	Responsible for PA approvals of chemotherapy and radiation protocols, PET scans and genetic/molecular testing.
Clinical Medical Services	Responsible for approvals of DME.
TNPR	Responsible for preservice organization determinations of therapy services.

Triple S Platino has a committee that meets on a quarterly basis to conduct an analysis of PH and MH services including a comparison of the services that require prior authorization, the process, denial rates, readmission rates and average lengths of stay. The MAO developed a policy for Compliance with MH Parity Law and performs a yearly comprehensive analysis to assess NQTL compliance for the program. The 2022 analysis did not identify any critical disparities between PH and MH.

MAO staff provided responses that were consistent with each other and the documentation in regard to the timeframe for PA decisions and providing written notice of adverse benefit determinations, that emergency and post stabilization services do not require a referral or prior authorization, and that staff are not incentivized for making UM decisions.

Findings

Triple S Platino met all requirements for these metrics through RFI documents, on-site discussions, and post-on-site submissions.

G&A

A review of G&A covered the following areas:

- General grievance system requirements, including:
  - Information about the grievance systems shared with providers and subcontractors
  - Grievance system P&Ps
  - Authority to file
  - Handling of G&A
  - Recordkeeping requirements
- Grievance system management, including the grievance process and resolution and notification
- Appeals process management, including the appeals process and resolution and notification

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MAO has in effect a grievance and appeal system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform Enrollees of their rights under grievance, appeal, and State Fair Hearing processes. The MAO must inform Enrollees of how to access the grievance system, the availability of the MAO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MAO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MAO provides NOABD letters that are compliant with language, content, and format as required by Enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MAO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MAO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MAO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MAO must keep a log of all G&As filed. The MAO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate the Triple S Platino compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the Triple S Platino RFI response and supporting documentation including P&Ps, Enrollee Handbook, Enrollee website, G&A department structure, and program highlights. This review was conducted based on information submitted by Triple S Platino through the RFI and through on-site meetings held on October 26, 2023. The on-site meetings involved key leadership from the MAO including but not limited to:

- Supervisor, G&A
- Analyst, G&A Quality
- Manager, G&A
- Senior Compliance Auditor
- Compliance Auditor
- Customer Services Enrollee

Overall Assessment

Triple S Platino has a dedicated G&A department to manage Enrollee grievances and appeals. Enrollee complaints are received and managed by the Customer Services Call Center. If the case is not resolved within 72 hours, the case is referred to the G&A department as a grievance. The grievance system follows standard processes. Grievances can be received from Enrollees, Enrollee representatives, or providers verbally through Customer Services Call Center or in-person at a service center, or be written (i.e., filling out a form on the Triple S Platino website and submitting it, fax, or mail). G&A are documented and monitored in the VAM system. Triple S Platino delegates Enrollee G&A related to MH services to APS. APS follows the same process for receiving and resolving G&As. APS presents reports to the UM committee on a quarterly basis and G&A data is also included in

the annual evaluation review. Triple S Platino monitors Enrollee satisfaction with its services and identifies areas for improvement on a quarterly basis using G&A data.

Grievance staff facilitate the grievance investigation, producing and sending Enrollee notification letters, and coordinating investigations with other impacted business units. For example, the PNM team will be sent quality of service grievances and QOC grievances are sent to the Quality team. QOC grievances are also tracked and reported to the QIC. The timeframe for grievance resolution starts the day the MAO receives the initial complaint or grievance. Grievance acknowledgement letters are sent within 10 business days and resolution letters within 30 calendar days of receipt of the grievance.

Enrollee complaints are documented, tracked, and metrics are monitored by Customer Service department through a customer relationship management system. If the case is not resolved within 72 hours, the customer service representative refers the case to G&A Department as a grievance. Enrollee complaints data is included in quarterly reporting to ASES using Report 21 template. For grievances that start as a complaint, the time spent on investigating the complaint is deducted from the 30-day resolution timeline for grievances.

Similar to grievances, standard appeals are accepted both verbally (through Enrollee Services) or in writing (appeals form can be found on the MAO's website) and sent to Triple S Platino via US mail, fax, or Enrollee portal. Appeals filed by providers are required to have written Enrollee consent. The appeal start date is the date the initial appeal is received. There is an opportunity for the MAO to review their P&Ps to ensure there is no confusion between Medicare and Medicaid requirements and that definitions are aligned with the Platino contract.

Appeals staff are responsible for sending out Enrollee correspondence including the initial acknowledgement letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuity of care is requested in the appeal, the analyst checks to ensure the proper steps have occurred and timelines are met. The Enrollee or Enrollee representative has the opportunity to present the case and answer any questions. A G&A technician or specialist logs the appeal in the VAM system. The case is reviewed by a physician, and a decision is issued and communicated to the Enrollee verbally and written. If the case is overturned, the G&A specialist coordinates services as expeditiously as the Enrollee's health requires (no later than 30 days). If the case is upheld, the G&A representative documents the decision and refers the case to a Maximus Specialist or G&A Supervisor. In the case of an upheld appeal decision when the Enrollee continues to receive benefits, the MAO does not recover costs for those services.

Findings

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
The MAO has a written Grievance system under which Enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for,	Partially Met.	Enrollee complaints are managed in Enrollee Services department rather than as an integrated	Develop P&Ps to support contract requirements outlined in Article 11 including

Regulation/Contract Standard Not Fully Compliant	2023 Review Score	Finding	Recommendation
Covered Services. The Grievance system includes a Complaint process, Grievance process, Appeal process, and access to the ALH process. (42 CFR part 422 Subpart M) (42 CFR Part 438, Subpart F) Platino Article 11.1; 11.1.2.		component of the G&A system. (11.1.2)	appropriate definitions for and tracking and trending of complaint, grievance, and appeals data.
The MAO's G&A system fully complies with the Puerto Rico's Patient Bill of Rights Act, to the extent that such provisions do not conflict with or post an obstacle to federal regulations. The advisory board's advice to the MAO on resolution of Enrollee G&A. (42 C.F.R. §438.406) (Platino 11.1.6)	Partially Met.	Policy AG 003 (R.10) says the MAO may charge the Enrollee a reasonable cost for copying and mailing an appeal case file.	Update G&A P&Ps to align with the Platino Contract. (11.5.2)

QAPI Program

A review of the QAPI program includes the following:

- The presence of an ongoing comprehensive QAPI program
- Monitoring and assessment of the QAPI
- Analysis and reporting of the QAPI
- Performance measurement
- QI initiatives

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MAO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, claims, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330.

The intent of this regulation is to ensure the MAO has an ongoing quality assessment and performance improvement program for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with SHCN.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the Triple S Platino organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through on-site meetings held October 26, 2023. The on-site meetings involved participation from MAO key leadership including, but not limited to:

- QI Director
- Federal Programs Supervisor
- Compliance Auditor
- HEDIS and Stars Senior Director
- Customer Service Manager

Overall Assessment

Mercer found all required documentation provided evidence of compliance with regulatory or contractual provisions. During the on-site review, Mercer also observed Triple S Platino staff provided responses that were consistent with each other and with the submitted documentation.

The Mercer assessment further found that the MAO illustrates a comprehensive, federally compliant, QI program description including a primary goal to develop, implement, and monitor ongoing quality initiatives and processes to ensure QOC and services to Enrollees. The Triple S Platino comprehensive QI management system is data driven and supports the entire QI operation. Data collection, analysis, and reporting processes are well documented throughout the Triple S Platino P&Ps.

Additionally, Triple S Platino illustrates a thorough, comprehensive process with policies supporting the integral Plan Performance Monitoring and Evaluation. A diverse expert team and quality committees are responsible for performing dedicated ongoing evaluations throughout the year and annually for the purpose of annual reporting and for the development, implementation, and updates of the QI work plan. Prior year evaluations and goals are a part of the annual evaluation and assist with trend analysis. A total plan component evaluation is illustrated with a focus on effectiveness and identification of areas for improvement with a final internal approval process as a critical component of the overall evaluation process. A PDSA methodology for the monitoring of goals and metrics is utilized

within the Triple S Platino quality committee structure as well as the encouragement of provider participation and Enrollee feedback.

Lastly, the MAO QAPI illustrates its CCIP process that produces a three-year study and utilizes a PDSA methodology with a focus on improvement of clinical outcomes and assessing for over/under utilization. The PRMP does not direct the MAOs to develop specific PIPs, however, the MAO's policy ensures performance improvement through its MOC program with an ongoing process for annual evaluation and reporting. HEDIS and STARS measure improvement, as well as Enrollee satisfaction, are integrated in the CCIP. The QAPI program description also contains prescriptive corrective actions aimed at improving any metric failure.

Findings

Triple S Platino met all requirements for these metrics through RFI documents, on-site discussions, and post on-site submissions.

Appendix C
GHP PM Reporting

Results of all Collected HEDIS Measures

Medicaid MCOs were required to report their HEDIS measure rates, numerators, and denominators for MYs 2018–2022. The MCOs reported rates were compiled and compared to national benchmarks. For MY 2018 and MY 2019, comparison is made to the Medicaid HMO National Average in the State of Healthcare Quality Report[4]. For MY 2020, MY 2021, and MY 2022, comparison is made to the NCQA national average category "All LOBs Excluding PPOs and EPO" in the NCQA Quality Compass® Medicaid. If a lower rate is desirable, it is noted in the table. If a measure met or scored above the National Average, it is reported in green.

Please note that MCOs reported rates differently, some with two decimal points and others only one decimal point. Mercer is providing the reported HEDIS audited rates. For the IET measure, HEDIS specifications uses age brackets listed; however, some MCOs reported rates for ages 13 Years–17 Years, 18+ Years, and Total.

HEDIS MY 2018 Rates

The following table displays MY 2018 rates reported by FMHP, MMM, Molina, and Triple S. PSM started operation at the end of 2018; therefore, PSM will not have MY 2018 rates.

HEDIS MY 2018	FMHP	MMM	Molina	Triple S
Effectiveness of Care: Prevention and Screening				
Adult BMI Assessment (ABA)	—	37.99%	52.71%	27.51%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile				
3 Years–11 Years*	7.3%	—	—	—
12 Years–17 Years*	7.3%	—	—	—
Total	—	24.26%	36.67%	18.55%
Nutrition Counseling				
3 Years–11 Years*	4.0%	—	—	—
12 Years–17 Years*	4.3%	—	—	—

[4] The State of Healthcare Quality Report, available on the NCQA HEDIS Measures and Technical Resources website (https://www.ncqa.org/hedis/measures/).

* For this measure, a lower rate indicates better performance.

HEDIS MY 2018	FMHP	MMM	Molina	Triple S
Total	—	7.15%	27.47%	10.73%
Physical Activity Counseling				
3 Years–11 Years*	0.3%	—	—	—
12 Years–17 Years*	0.3%	—	—	—
Total	—	1.45%	9.78%	1.07%
Childhood Immunization Status (CIS)				
DTaP	34.0%	60.02%	36.50%	0.26%
IPV	50.4%	78.55%	55.73%	2.88%
MMR	65.1%	79.77%	73.38%	41.88%
HiB	56.2%	81.56%	65.84%	7.85%
Hepatitis B	13.5%	66.09%	9.02%	0.00%
VZV	64.6%	77.96%	70.50%	43.46%
Pneumococcal Conjugate	31.4%	54.10%	34.81%	0.79%
Hepatitis A	66.6%	80.21%	69.73%	47.12%
Rotavirus	27.4%	49.78%	35.95%	4.71%
Influenza	9.7%	14.62%	20.09%	3.14%
Combination 2	—	47.43%	4.80%	0.00%
Combination 3	6.9%	42.67%	4.04%	0.00%
Combination 4*	—	42.45%	3.84%	0.00%
Combination 5*	—	29.68%	2.85%	0.00%
Combination 6*	—	9.96%	1.43%	0.00%
Combination 7*	4.5%	29.68%	2.70%	0.00%
Combination 8*	—	9.96%	1.40%	0.00%
Combination 9*	—	7.83%	0.96%	0.00%
Combination 10*	1.0%	7.83%	0.93%	0.00%
Lead Screening in Children (LSC)	—	—	16.86%	—
Breast Cancer Screening (BCS): Total	58.8%	62.33%	70.89%	56.64%
Cervical Cancer Screening (CCS)	50.0%	52.99%	59.13%	45.90%

* For this measure, a lower rate indicates better performance.

HEDIS MY 2018	FMHP	MMM	Molina	Triple S
Colorectal Cancer Screening (COL)*				
46 Years–49 Years	NR	—		—
50 Years–75 Years	45.4%	—		—
Chlamydia Screening in Women (CHL)				
16 Years–20 Years*	—	—	—	48.31%
21 Years–24 Years*	—	—	—	48.67%
Total	—	58.69%	56.31%	48.51%
Effectiveness of Care: Respiratory Conditions				
Medication Management for People with Asthma (MMA)*				
Total: Medication Compliance 50%	—	58.76%	54.17%	64.15%
Total: Medication Compliance 75%	—	27.69%	27.42%	39.62%
Effectiveness of Care: Cardiovascular Conditions				
Controlling High Blood Pressure (CBP)	0.0%	22.35%	38.75%	25.43%
Statin Therapy for Patients With Cardiovascular Disease (SPC)				
Received Statin Therapy: Total	—	—	72.21%	—
Statin Adherence 80%: Total	—	—	50.66%	—
Effectiveness of Care: Diabetes				
Comprehensive Diabetes Care (CDC)				
Hemoglobin A1c (HbA1c) Testing	—	72.88%	82.47%	79.10%
HbA1c Control (<7.0%)*	—	6.62%	—	5.66%
HbA1c Control (<8.0%)	0.0%	6.56%	9.97%	5.52%
HbA1c Poor Control (>9.0%)**	100.0%	88.04%	83.48%	89.79%
BP Control <140/90 mm Hg	0.0%	17.30%	38.37%	22.53%
Eye Exam for Patients With Diabetes	25.3%	29.65%	41.29%	33.76%
Medical Attention for Nephropathy	—	92.11%	93.45%	93.48%
Effectiveness of Care: Behavioral Health				

* For this measure, a lower rate indicates better performance.

** For this measure, a lower rate indicates better performance.

HEDIS MY 2018	FMHP	MMM	Molina	Triple S
Antidepressant Medication Management (AMM)				
Acute	41.6%	48.01%	44.55%	44.74%
Continuation	26.4%	32.13%	29.55%	36.84%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation	44.1%	92.47%	43.04%	—
Continuation	55.9%	100.00%	66.04%	—
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up				
6 Years–17 Years*	45.1%	—	—	48.28%
18 Years–64 Years*	41.1%	—	—	51.02%
65+ Years*	36.8%	—	—	20.00%
Total	—	69.90%	54.69%	49.24%
30-Day Follow-Up				
6 Years–17 Years*	64.2%	—	—	82.76%
18 Years–64 Years*	59.5%	—	—	74.49%
65+ Years*	57.9%	—	—	40.00%
Total	—	82.92%	73.06%	75.00%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	62.4%	63.33%	—	78.82%
Effectiveness of Care: Overuse/Appropriateness				
Appropriate Treatment for Upper Respiratory Infection (URI): Total	21.6%	80.53%	20.40%^	—
Access/Availability of Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP): Total	—	73.00%	71.55%	70.13%

* For this measure, a lower rate indicates better performance.

^ The 2018 Auditor-Locked IDSS submitted by Molina reported 2,753 for the numerator, 13,492 for the denominator and 79.60% for the rate. The rate included in the table has been recalculated based on the reported numerator and denominator.

HEDIS MY 2018	FMHP	MMM	Molina	Triple S
Children and Adolescents' Access to Primary Care Practitioners (CAP)*				
12 Months–24 Months	—	81.19%	83.84%	81.13%
25 Months–6 Years	—	79.70%	76.97%	76.84%
7 Years–11 Years	—	85.54%	84.82%	78.67%
12 Years–19 Years	—	76.52%	78.43%	69.64%
Total	—	—	—	—
Annual Dental Visit (ADV): Total	—	63.98%	54.07%	59.69%
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	15.4%[5]	67.28%	50.89%	78.38%
Postpartum Care	77.5%[6]	19.35%	9.41%	16.22%
Well-Child Visits in the First 15 Months of Life (W15)*				
0 Visits	—	18.01%	21.62%	38.66%
1 Visit	—	11.50%	16.06%	26.02%
2 Visits	—	13.30%	14.67%	13.38%
3 Visits	—	12.08%	13.61%	9.29%
4 Visits	—	10.75%	10.26%	5.20%
5 Visits	—	9.24%	8.28%	5.20%
6+ Visits	—	25.13%	15.50%	2.23%
Adolescent Well-Care Visits (AWC)*	—	42.85%	29.67%	28.39%

HEDIS MY 2019 Rates

The following table displays MY 2019 rates reported by FMHP, MMM, Molina, PSM, and Triple S.

HEDIS MY 2019	FMHP	MMM	Molina	PSM	Triple S
Effectiveness of Care: Prevention and Screening					
Adult BMI Assessment (ABA)	—	53.3%	61.93%	—	18.95%

* For this measure, a lower rate indicates better performance.

[5] The rates in this table represent the data as reported by the MCO; however, the EQRO suspects the reported rate for Timeliness of Prenatal Care is the rate for Postpartum Care.

[6] The rates in this table represent the data as reported by the MCO; however, the EQRO suspects the reported rate for Postpartum Care is the rate for Timeliness of Prenatal Care.

HEDIS MY 2019	FMHP	MMM	Molina	PSM	Triple S
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI Percentile					
3 Years–11Years*	2.0%	—	—	—	12.46%
12 Years–17 Years*	1.9%	—	—	—	14.15%
Total	—	54.5%	47.75%	41.0%	13.07%
Nutrition Counseling					
3 Years–11Years*	3.3%	—	—	—	5.72%
12 Years–17 Years*	4.6%	—	—	—	6.52%
Total	—	51.3%	36.20%	30.6%	6.01%
Physical Activity Counseling					
3 Years–11Years*	0.4%	—	—	—	1.60%
12 Years–17 Years*	0.4%	—	—	—	1.93%
Total	—	47.4%	17.90%	8.7%	1.72%
Childhood Immunization Status (CIS)					
DTaP	26.1%	72.7%	63.86%	0.0%	0.92%
IPV	39.1%	77.6%	82.81%	0.0%	9.15%
MMR	62.9%	81.8%	82.65%	41.9%	42.32%
HiB	48.6%	78.8%	81.97%	0.0%	12.36%
Hepatitis B	9.2%	76.2%	81.38%	0.0%	3.74%
VZV	64.0%	80.8%	81.97%	39.2%	41.79%
Pneumococcal Conjugate	22.3%	67.4%	50.38%	0.0%	1.06%
Hepatitis A	68.5%	83.9%	80.29%	58.6%	37.79%
Rotavirus	18.7%	58.9%	55.18%	0.0%	5.41%
Influenza	9.9%	24.3%	21.82%	5.3%	2.60%
Combination 2	—	60.6%	59.39%	0.0%	0.22%
Combination 3	4.2%	55.2%	46.08%	0.0%	0.22%

* For this measure, a lower rate indicates better performance.

HEDIS MY 2019	FMHP	MMM	Molina	PSM	Triple S
Combination 4*	—	55.2%	45.41%	0.0%	0.18%
Combination 5*	—	44.0%	36.31%	0.0%	0.09%
Combination 6*	—	18.5%	14.83%	0.0%	0.0%
Combination 7*	1.8%	44.0%	35.89%	0.0%	0.04%
Combination 8*	—	18.5%	14.74%	0.0%	0.0%
Combination 9*	—	15.6%	11.96%	0.0%	0.0%
Combination 10	0.6%	15.6%	11.88%	0.0%	0.0%
Immunizations for Adolescents (IMA)					
Meningococcal	—	—	86.98%	—	—
Tdap	—	—	87.33%	—	—
HPV	—	—	49.66%	—	—
Combination 1*	—	—	85.54%	—	—
Combination 2	—	—	48.55%	—	—
Breast Cancer Screening (BCS): Total	62.4%	67.3%	74.19%	—	53.14%
Cervical Cancer Screening (CCS)	45.5%	43.1%	60.00%	28.1%	27.02%
Chlamydia Screening in Women (CHL)					
16 Years–20 Years	—	—	—	—	21.42%
21 Years–24 Years	—	—	—	—	19.42%
Total	—	59.3%	59.77%	54.4%	20.17%
Colorectal Cancer Screening (COL)*					
46 Years–49 Years	NA	—	—	—	—
50 Years–75 Years	51.8%	—	—	—	—
Effectiveness of Care: Respiratory Conditions					
Appropriate Testing for Pharyngitis (CWP)	—	—	0.63%	—	—

* For this measure, a lower rate indicates better performance.

HEDIS MY 2019	FMHP	MMM	Molina	PSM	Triple S
Pharmacotherapy Management of COPD Exacerbation (PCE)					
Systemic Corticosteroids	—	—	29.02%	—	—
Bronchodilator	—	—	73.58%	—	—
Asthma Medication Ratio (AMR): Total*					
Medication Management for People with Asthma (MMA)*					
Total: Medication Compliance 50%	—	75.5%	54.77%	—	76.18%
Total: Medication Compliance 75%	—	55.4%	30.79%	—	57.23%
Effectiveness of Care: Cardiovascular Conditions					
Controlling High Blood Pressure (CBP)	NA	46.7%	43.85%	40.1%	11.08%
Statin Therapy for Patients With Cardiovascular Disease (SPC)					
Received Statin Therapy: Total	—	—	71.37%	—	—
Statin Adherence 80%: Total	—	—	55.91%	—	—
Statin Therapy for Patients with Diabetes (SPD)					
Received Statin Therapy: Total	—	—	64.15%	—	—
Statin Adherence 80%: Total	—	—	54.50%	—	—
Effectiveness of Care: Diabetes					
Comprehensive Diabetes Care (CDC)					
Hemoglobin A1c (HbA1c) Testing	—	77.6%	84.80%	78.5%	23.84%
HbA1c Poor Control (>9.0%)**	7.4%	61.6%	80.13%	85.5%	97.50%
HbA1c Control (<8.0%)	90.6%	28.5%	13.33%	9.7%	1.62%

* For this measure, a lower rate indicates better performance.

** NCQA national average was not available for comparison.

HEDIS MY 2019	FMHP	MMM	Molina	PSM	Triple S
HbA1c Control (<7.0%)*	—	19.5%	—	10.0%	1.32%
Eye Exam for Patients With Diabetes	25.1%	22.1%	45.96%	22.3%	15.54%
Medical Attention for Nephropathy	—	94.1%	94.05%	93.4%	81.44%
BP Control <140/90 mm Hg	0.0%	55.5%	46.06%	36.7%	11.46%
Effectiveness of Care: Behavioral Health					
Antidepressant Medication Management (AMM)					
Acute	37.5%	55.0%	49.65%	65.9%	—
Continuation	16.4%	49.3%	32.58%	52.8%	—
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation	45.2%	53.4%	55.50%	—	42.60%
Continuation	70.8%	75.0%	91.30%	—	46.15%
Follow-Up After Hospitalization for Mental Illness (FUH)					
7-Day Follow-Up					
6 Years–17 Years*	46.9%	—	—	—	—
18 Years–64 Years*	39.3%	—	—	—	—
65+ Years*	48.4%	—	—	—	—
Total	—	58.0%	62.33%	42.9%	—
30-Day Follow-Up					
6 Years–17 Years*	69.1%	—	—	—	—
18 Years–64 Years*	58.3%	—	—	—	—
65+ Years*	67.7%	—	—	—	—
Total	—	77.1%	78.63%	61.7%	—
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					

* For this measure, a lower rate indicates better performance.

HEDIS MY 2019	FMHP	MMM	Molina	PSM	Triple S
Follow-Up Within 7 Days: Total	—	—	26.94%	—	—
Follow-Up Within 30 Days: Total	—	—	46.12%	—	—
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)					
Follow-Up Within 7 Days: Total	—	—	14.78%	—	—
Follow-Up Within 30 Days: Total	—	—	20.87%	—	—
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	72.9%	41.9%	68.71%	58.0%	22.18%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	—	—	69.30%	—	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Blood Glucose	—	—	60.94%	—	—
Cholesterol	—	—	48.48%	—	—
Blood Glucose and Cholesterol	—	—	47.37%	—	—
Effectiveness of Care: Overuse/Appropriateness					
Appropriate Treatment for Upper Respiratory Infection (URI)					
3 Months–17 Years	—	—	—	—	21.05%
18 Years–64 Years	—	—	—	—	35.04%
65+ Years	—	—	—	—	43.89%
Total	15.2%	69.1%	28.95%	27.9%	27.35%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	—	—	46.66%	—	—

HEDIS MY 2019	FMHP	MMM	Molina	PSM	Triple S
Use of Imaging Studies for Low Back Pain (LBP)	—	—	23.91%	—	—
Use of Opioids from Multiple Providers (UOP)**					
Multiple Prescribers	—	—	2.29%	—	—
Multiple Pharmacies	—	—	4.67%	—	—
Multiple Prescribers and Multiple Pharmacies	—	—	0.55%	—	—
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP): Total	—	72.9%	77.97%	70.0%	45.03%
Children and Adolescents' Access to Primary Care Practitioners (CAP)*					
12 Months–24 Months	—	—	—	—	40.80%
25 Months–6 Years	—	—	—	—	32.87%
7 Years–11 Years	—	—	—	—	79.17%
12 Years–19 Years	—	—	—	—	70.58%
Total	—	82.2%	—	77.2%	—
Annual Dental Visit (ADV)					
2 Years–3 Years*	—	—	—	—	52.11%
4 Years–6 Years*	—	—	—	—	76.97%
7 Years–10 Years*	—	—	—	—	78.22%
11 Years–14 Years*	—	—	—	—	73.98%
15 Years–18 Years*	—	—	—	—	63.15%
19 Years–20 Years*	—	—	—	—	45.38%
Total	—	63.6%	59.55%	64.9%	—
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)					

** NCQA national average was not available for comparison.

* For this measure, a lower rate indicates better performance.

HEDIS MY 2019	FMHP	MMM	Molina	PSM	Triple S
Initiation of AOD Treatment: Total	—	—	39.00%	—	—
Engagement of AOD Treatment: Total	—	—	10.97%	—	—
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care	85.2%	99.0%	62.50%	24.9%	76.85%
Postpartum Care	37.8%	39.9%	25.17%	39.6%	22.76%
Well-Child Visits in the First 15 Months of Life (W15)*					
0 Visits	—	10.9%	—	15.8%	42.61%
1 Visit	—	10.7%	—	15.8%	22.04%
2 Visits	—	12.4%	—	18.4%	13.74%
3 Visits	—	11.4%	—	10.5%	9.67%
4 Visits	—	9.0%	—	15.8%	5.83%
5 Visits	—	9.2%	—	13.2%	2.99%
6+ Visits	—	36.3%	—	10.5%	3.13%
Adolescent Well-Care Visits (AWC)*	—	39.2%	—	32.1%	6.05%

HEDIS MY 2020 Rates

The following table displays MY 2020 rates reported by FMHP, MMM, PSM, and Triple S[7]. Molina's contract ended in November 2020, as such, Molina will not have MY 2020 rates.

HEDIS MY 2020	FMHP	MMM	PSM	Triple S
Effectiveness of Care: Prevention and Screening				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile				
3 Years–11Years*	0.6%	—	—	24.7%
12 Years–17 Years*	0.7%	—	—	26.8%

* For this measure, a lower rate indicates better performance.

[7] For MY 2020, Triple-S submitted ASES Report 24, not the NCQA audited version.

HEDIS MY 2020	FMHP	MMM	PSM	Triple S
Total	—	13.27%	9.37%	—
Nutrition Counseling				
3 Years–11Years*	2.5%	—	—	14.0%
12 Years–17 Years*	4.2%	—	—	14.2%
Total	—	26.99%	29.96%	—
Physical Activity Counseling				
3 Years-11Years*	0.2%	—	—	7.9%
12 Years-17 Years*	0.2%	—	—	8.0%
Total	—	12.62%	34.34%	—
Childhood Immunization Status (CIS)				
DTaP	8.7%	—	—	—
IPV	16.8%	—	—	—
MMR	66.6%	—	—	—
HiB	25.9%	—	—	—
Hepatitis B	3.3%	—	—	—
VZV	66.7%	—	—	—
Pneumococcal Conjugate	8.6%	—	—	—
Hepatitis A	66.1%	—	—	—
Rotavirus	9.6%	—	—	—
Influenza	5.5%	—	—	—
Combination 2	—	—	—	—
Combination 3	1.5%	—	—	—
Combination 4*	—	—	—	—
Combination 5*	—	—	—	—
Combination 6*	—	—	—	—
Combination 7*	1.0%	—	—	—
Combination 8*	—	—	—	—
Combination 9*	—	—	—	—

* For this measure, a lower rate indicates better performance.

HEDIS MY 2020	FMHP	MMM	PSM	Triple S
Combination 10	0.1%	—	—	—
Breast Cancer Screening (BCS): Total	55.0%	61.70%	—	42.7%
Cervical Cancer Screening (CCS)	—	45.91%	37.09%	32.5%
Chlamydia Screening in Women (CHL)				
16 Years–20 Years	—	—	—	56.5%
21 Years–24 Years	—	—	—	55.3%
Total	—	57.97%	56.83%	—
Colorectal Cancer Screening (COL)*				
46–49 Years	NA	—	—	
50–75 Years	38.5%	—	—	
Effectiveness of Care: Respiratory Conditions				
Asthma Medication Ratio (AMR)				
5 Years–11 Years	99.0%	—	—	97.9%
12 Years–18 Years	92.4%	—	—	91.7%
19 Years–50 Years	80.9%	—	—	73.1%
51 Years–64 Years	74.9%	—	—	70.4%
Total	—	76.86%	70.17%	—
Effectiveness of Care: Cardiovascular Conditions				
Controlling High Blood Pressure (CBP)	82.9%	48.91%	32.23%	57.7%
Effectiveness of Care: Diabetes				
Comprehensive Diabetes Care (CDC)				
Hemoglobin A1c (HbA1c) Testing	—	72.75%	65.73%	72.5%
HbA1c Poor Control (>9.0%)**	87.7%	63.02%	86.89%	—
HbA1c Control (<8.0%)	12.9%	29.93%	11.46%	39.9%
Eye Exam for Patients with Diabetes	20.4%	40.15%	20.92%	36.7%
BP Control <140/90 mm Hg	0.0%	53.04%	30.12%	61.6%

** NCQA national average was not available for comparison.

HEDIS MY 2020	FMHP	MMM	PSM	Triple S
Kidney Health Evaluation for Patients with Diabetes (KED): Total*	11.4%	8.84%	—	—
18 Years–64 Years	—	—	—	10.0%
65 Years–74 Years	—	—	—	10.1%
75 Years–85 Years	—	—	—	10.3%
Effectiveness of Care: Behavioral Health				
Antidepressant Medication Management (AMM)				
Acute	47.2%	37.48%	55.31%	49.8%
Continuation	26.4%	31.07%	42.94%	38.6%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation	57.5%	47.98%	64.63%	22.2%
Continuation	NR	69.57%	37.39%	35.8%
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up				
6 Years–17 Years*	36.5%	—	—	33.7%
18 Years–64 Years*	39.5%	—	—	24.5%
65+ Years*	41.2%	—	—	16.0%
Total	—	52.42%	64.63%	—
30-Day Follow-Up				
6 Years–17 Years*	62.9%	—	—	56.4%
18 Years–64 Years*	66.8%	—	—	46.9%
65+ Years*	50.0%	—	—	32.0%
Total	—	73.30%	41.77%	—
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	52.5%	20.69%	40.70%	24.7%
Effectiveness of Care: Overuse/Appropriateness				

* For this measure, a lower rate indicates better performance.

HEDIS MY 2020	FMHP	MMM	PSM	Triple S
Appropriate Treatment for Upper Respiratory Infection (URI)				
3 Months–17 Years	—	—	—	34.4%
18 Years–64 Years	—	—	—	41.4%
65+ Years	—	—	—	42.1%
Total	28.4%	28.61%	31.63%	—
Access/Availability of Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
20 Years–44 Years				65.0%
43 Years–64 Years				80.6%
65+ Years				81.3%
Total	—	70.13%	67.23%	—
Annual Dental Visit (ADV): Total	—	35.87%	35.36%	—
2 Years–3 Years	—	—	—	24.6%
4 Years–6 Years	—	—	—	41.3%
7 Years–10 Years	—	—	—	43.6%
11 Years–14 Years	—	—	—	39.4%
15 Years–18 Years	—	—	—	36.9%
19 Years–20 Years	—	—	—	32.2%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation: Alcohol				
13 Years–17 Years	100.0%	—	—	—
18 Years–64 Years	94.1%	—	—	—
65+ Years	94.1%	—	—	—
Initiation: Opioid				
13 Years–17 Years	100.0%	—	—	—
18 Years–64 Years	93.5%	—	—	—
65+ Years	88.9%	—	—	—

HEDIS MY 2020	FMHP	MMM	PSM	Triple S
Initiation: Other				
13 Years–17 Years	85.3%	—	—	—
18 Years–64 Years	91.8%	—	—	—
65+ Years	56.3%	—	—	—
Initiation: Total	—	49.41%	34.26%	—
Engagement: Alcohol				
13 Years–17 Years	0.0%	—	—	—
18 Years–64 Years	13.6%	—	—	—
65+ Years	5.9%	—	—	—
Engagement: Opioid				
13 Years–17 Years	0.0%	—	—	—
18 Years–64 Years	21.8%	—	—	—
65+ Years	22.2%	—	—	—
Engagement: Other				
13 Years–17 Years	8.8%	—	—	—
18 Years–64 Years	9.1%	—	—	—
65+ Years	0.0%	—	—	—
Engagement: Total		14.28%	7.91%	—
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	74.6%	87.35%	42.12%	89.1%
Postpartum Care	33.2%	46.47%	22.85%	61.6%
Utilization				
Well-Child Visits in the First 30 Months of Life (W30)				
Age 15 Months	4.2%	12.97%	13.42%	0.5%
Age 15 Months–30 Months	21.5%	37.80%	40.62%	9.6%
Child and Adolescent Well-Care Visits (WCV)				
3 Years–11 Years	20.1%	—	—	33.0%
12 Years–17 Years	17.0%	—	—	29.5%

HEDIS MY 2020	FMHP	MMM	PSM	Triple S
18 Years–21 Years	9.3%	—	—	18.4%
Total	—	—	24.96%	—

HEDIS MY 2021 Rates

The following table displays MY 2021 rates reported by FMHP, MMM, PSM, and Triple S.

HEDIS MY 2021	FMHP	MMM	PSM	Triple S
Effectiveness of Care: Prevention and Screening				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile				
3 Years–11Years*	—	—	46.6%	31.00%
12 Years–17 Years*	—	—	47.1%	31.86%
Total	—	30.69%	—	31.34%
Nutrition Counseling				
3 Years–11 Years*	—	—	42.3%	18.77%
12 Years–17 Years*	—	—	43.8%	18.26%
Total	—	33.60%	—	18.57%
Physical Activity Counseling				
3 Years–11Years*	—	—	18.8%	12.25%
12 Years–17 Years*	—	—	20.0%	11.76%
Total	—	18.24%	—	12.05%
Childhood Immunization Status (CIS)				
DTaP	25.8%	—	11.6%	7.43%
IPV	43.0%	—	21.0%	11.22%
MMR	58.7%	—	51.6%	53.53%
HiB	50.1%	—	27.1%	19.44%
Hepatitis B	6.9%	—	5.9%	2.67%
VZV	58.2%	—	50.7%	54.34%

* For this measure, a lower rate indicates better performance.

HEDIS MY 2021	FMHP	MMM	PSM	Triple S
Pneumococcal Conjugate	23.8%	—	10.2%	6.79%
Hepatitis A	58.1%	—	57.2%	52.79%
Rotavirus	27.3%	—	14.7%	6.79%
Influenza	5.6%	—	8.0%	5.45%
Combination 3	3.0%	—	2.1%	1.72%
Combination 7*	1.7%	—	0.9%	0.95%
Combination 10	0.0%[8]	—	0.2%	0.13%
Immunizations for Adolescents (IMA)				
Combination 1	53.6%	—	39.5%	—
Combination 2	25.8%	—	17.9%	—
HPV	28.5%	—	20.8%	—
Meningococcal	56.1%	—	40.6%	—
Tdap	57.6%	—	45.8%	—
Colorectal Cancer Screening (COL)*				
46 Years–49 Years	NR	—	—	—
50 Years–75 Years	46.3%	—	—	—
Breast Cancer Screening (BCS): Total	55.3%	52.79%	59.0%	59.18%
Cervical Cancer Screening (CCS)	42.2%	47.68%	42.5%	38.31%
Chlamydia Screening in Women (CHL)				
16 Years–20 Years	—	—	58.8%	60.23%
21 Years–24 Years	—	—	65.2%	58.48%
Total	—	62.77%	—	59.23%
Effectiveness of Care: Respiratory Conditions				
Asthma Medication Ratio (AMR)				
5 Years–11 Years	99.2%	—	77.9%	98.00%
12 Years–18 Years	93.9%	—	81.5%	90.71%
19 Years–50 Years	82.1%	—	68.8%	73.22%
51 Years–64 Years	79.0%	—	67.3%	70.31%

* For this measure, a lower rate indicates better performance.

[8] Please note that the reported rate of 0.0% is due to the rounding to one decimal place. The rate is 0.03%

HEDIS MY 2021	FMHP	MMM	PSM	Triple S
Total	—	73.07%	—	75.44%
Effectiveness of Care: Cardiovascular Conditions				
Controlling High Blood Pressure (CBP)	22.5%	62.04%	65.0%	53.53%
Effectiveness of Care: Diabetes				
Comprehensive Diabetes Care (CDC)				
Hemoglobin A1c (HbA1c) Testing	—	82.73%	85.4%	81.02%
HbA1c Poor Control (>9.0%)**	85.1%	54.01%	58.2%	48.42%
HbA1c Control (<8.0%)	15.0%	38.93%	35.3%	44.53%
Eye Exam for Patients with Diabetes	21.1%	31.63%	37.2%	42.82%
BP Control <140/90 mm Hg	23.1%	56.20%	58.4%	48.42%
Kidney Health Evaluation for Patients with Diabetes (KED)				
18 Years–64 Years	—	—	10.8%	13.09%
65 Years–74 Years	—	—	9.5%	14.89%
75 Years–85 Years	—	—	10.8%	13.27%
Total	12.3%	13.15%	—	13.31%
Effectiveness of Care: Behavioral Health				
Antidepressant Medication Management (AMM)				
Acute	44.2%	55.27%	67.1%	54.02%
Continuation	25.3%	44.95%	54.4%	42.67%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation	66.2%	55.07%	43.9%	33.18%
Continuation	NR	70.15%	45.5%	41.96%
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
Follow-Up 7 Days				

** NCQA national average was not available for comparison.

HEDIS MY 2021	FMHP	MMM	PSM	Triple S
13 Years–17 Years	14.3%	—	50.0%	—
18+ Years	10.5%	—	20.9%	—
Follow-Up 30 Days				
13 Years–17 Years	28.6%	—	50.0%	—
18+ Years	17.7%	—	30.2%	—
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up				
6 Years–17 Years	34.2%	—	56.9%	30.88%
18 Years–64 Years	27.8%	—	43.4%	24.59%
65+ Years	22.7%	—	54.2%	12.24%
Total	—	49.13%	—	25.15%
30-Day Follow-Up				
6 Years–17 Years	64.5%	—	88.3%	70.88%
18 Years–64 Years	56.2%	—	73.8%	56.53%
65+ Years	54.6%	—	70.8%	55.10%
Total	—	73.81%	—	58.44%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
Follow-Up 7 Days				
6 Years–17 Years	33.0%	—	52.6%	—
18 Years–64 Years	30.7%	—	29.4%	—
65+ Years	34.6%	—	25.0%	—
Follow-Up 30 Days				
6 Years–17 Years	71.8%	—	75.0%	—
18 Years–64 Years	54.7%	—	51.8%	—
65+ Years	53.8%	—	43.8%	—
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	34.1%	—	73.6%	—

HEDIS MY 2021	FMHP	MMM	PSM	Triple S
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	56.9%	60.93%	65.7%	63.55%
Effectiveness of Care: Overuse/Appropriateness				
Appropriate Treatment for Upper Respiratory Infection (URI)				
3 Months–17 Years	—	—	19.2%	77.17%
18 Years–64 Years	—	—	38.1%	67.07%
65+ Years	—	—	31.0%	72.77%
Total	32.2%	32.14%	—	71.34%
Avoidance Antibiotic Treatment (AAB)				
3 Months–17 Years	—	—	33.1%	
18 Years–64 Years	—	—	47.6%	
65+ Years	—	—	51.6%	
Access/Availability of Care				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
1 Year–11 Years	60.9%	—	42.9%	—
12 Years–17 Years	52.5%	—	42.3%	—
Total	—	69.65%	—	—
Adults' Access to Preventative and Ambulatory Health Services (AAP)				
20 Years–44 Years	—	—	—	64.79%
45 Years–65 Years	—	—	—	80.26%
65+ Years	—	—	—	81.02%
Total	—	—	—	71.49%
Annual Dental Visit (ADV): Total				
2 Years–3 Years	—	—	—	35.90%
4 Years–6 Years	—	—	—	58.25%
7 Years–10 Years	—	—	—	60.44%

HEDIS MY 2021	FMHP	MMM	PSM	Triple S
11 Years–14 Years	—	—	—	57.91%
15 Years–18 Years	—	—	—	52.51%
19 Years–20 Years	—	—	—	39.88%
Total	—	50.14%	50.3%	53.29%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation: Alcohol				
13 Years–17 Years	66.7%	—	—	25.00%
18 Years–64 Years	93.9%	—	—	39.91%
65+ Years	90.0%	—	—	—
Total	—	—	—	39.84%
Initiation: Opioid				
13 Years–17 Years	100.0%	—	—	NA
18 Years–64 Years	95.5%	—	—	57.79%
65+ Years	100.0%	—	—	—
Total	—	—	—	57.79%
Initiation: Other				
13 Years–17 Years	84.2%	—	—	29.73%
18 Years–64 Years	94.8%	—	—	43.51%
65+ Years	87.5%	—	—	—
Total	—	—	—	43.35%
Initiation: Total				
13 Years–17 Years	—	—	40.0%	30.23%
18 Years–64 Years	—	—	31.8%	43.10%[7]
65+ Years	—	—	—	—
Total	—	0.00%	—	43.00%
Engagement: Alcohol				
13 Years–17 Years	0.0%	—	—	0.00%
18 Years–64 Years	8.3%	—	—	7.02%[7]

HEDIS MY 2021	FMHP	MMM	PSM	Triple S
65+ Years	0.0%	—	—	—
Total	—	—	—	6.99%
Engagement: Opioid				
13 Years–17 Years	0.0%	—	—	NA
18 Years–64 Years	18.2%	—	—	21.16%
65+ Years	33.3%	—	—	—
Total	—	—		21.16%
Engagement: Other				
13 Years–17 Years	5.3%	—	—	8.11%
18 Years–64 Years	5.2%	—	—	10.68%
65+ Years	6.3%	—	—	—
Total				10.68%
Engagement: Total				
13 Years–17 Years	—	—	13.6%	6.98%
18 Years–64 Years	—	—	5.8%	11.11%
65+ Years				
Total	—	0.00%	—	11.07%
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	64.4%	93.92%	36.8%	85.64%
Postpartum Care	26.3%	52.31%	31.8%	66.67%
Well-Child Visits in the First 30 Months of Life (W30)				
Age 15 Months	1.3%	6.38%	8.4%	4.19%
Age 15–30 Months	11.5%	36.24%	36.2%	26.83%
Child Adolescent Well Visits (WCV)				
3 Years–11 Years	20.1%	—	44.8%	45.44%
12 Years–17 Years	17.1%	—	38.0%	38.98%
18 Years–21 Years	9.0%	—	23.7%	24.43%
Total	—	41.02%	—	38.43%

HEDIS MY 2022 Rates

The following table displays rates MY 2022 rates reported by MCO.

HEDIS MY 2022	FMHP	MMM	PSM	Triple S
Effectiveness of Care: Prevention and Screening				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile				
	0.2%	—	46.7%	33.68%
12 Years–17 Years*	0.3%	—	46.1%	34.82%
Total	—	36.49%	—	34.14%
Nutrition Counseling				
3 Years–11 Years*	2.5%	—	35.9%	20.71%
12 Years–17 Years*	3.2%	—	35.4%	20.96%
Total	—	34.12%	—	20.81%
Physical Activity Counseling				
3 Years–11 Years*	0.3%	—	22.1%	14.59%
12 Years–17 Years*	0.2%	—	20.9%	15.30%
Total	—	19.01%	—	14.87%
Childhood Immunization Status (CIS)				
DTaP	10.2%	15.79%	10.4%	14.72%
IPV	18.4%	21.49%	12.8%	21.67%
MMR	57.4%	70.21%	61.8%	65.24%
HiB	32.4%	40.64%	29.9%	38.99%
Hepatitis B	3.3%	3.51%	3.3%	5.33%
VZV	56.6%	67.32%	60.3%	65.31%
Pneumococcal Conjugate	9.8%	14.66%	10.1%	13.95%
Hepatitis A	61.3%	74.60%	68.1%	65.11%
Rotavirus	8.9%	12.17%	7.4%	12.30%
Influenza	6.9%	8.00%	11.1%	9.35%
Combination 3	1.1%	1.46%	1.8%	2.80%

HEDIS MY 2022	FMHP	MMM	PSM	Triple S
Combination 7	0.6%	0.58%	0.8%	1.76%
Combination 10	0.2%	0.22%	0.2%	0.24%
Immunizations for Adolescents (IMA)				
Meningococcal	55.0%	61.01%	47.2%	55.84%
Tdap	54.6%	60.88%	46.6%	55.74%
HPV	26.2%	20.34%	24.8%	30.90%
Combination 1	52.9%	59.33%	44.9%	54.27%
Combination 2	25.1%	19.69%	23.0%	29.61%
Lead Screening in Children (LSC): Total	22.6%	27.73%	30.1%	—
Breast Cancer Screening (BCS): Total	56.0%	62.01%	70.8%	65.14%
Cervical Cancer Screening (CCS)	42.4%	50.38%	51.3%	46.01%
Colorectal Cancer Screening (COL)*				
46 Years–49 Years	24.1%	—	22.6%	29.92%
50 Years–75 Years	38.7%	—	45.2%	46.59%
Total	—	44.93%	—	43.44%
Chlamydia Screening in Women (CHL)				
16 Years–20 Years	—	—	61.9%	56.13%
21 Years–24 Years	—	—	65.6%	60.79%
Total	—	63.49%	—	58.85%
Effectiveness of Care: Respiratory Conditions				
Asthma Medication Ratio (AMR)*				
5 Years–11 Years	97.4%	—	79.5%	95.32%
12 Years–18 Years	97.5%	—	84.7%	91.09%
19 Years–50 Years	89.4%	—	77.6%	72.09%
51 Years–64 Years	91.5%	—	76.0%	71.85%
Total	—	76.40%	—	75.58%
Effectiveness of Care: Cardiovascular Conditions				

* For this measure, a lower rate indicates better performance.

HEDIS MY 2022	FMHP	MMM	PSM	Triple S
Controlling High Blood Pressure (CBP)	25.8%	62.37%	50.2%	64.23%
Effectiveness of Care: Diabetes				
Hemoglobin A1c Control for Patients with Diabetes (HBD)				
HbA1c Control (<8.0%)	17.8%	43.31%	21.3%	42.82%
HbA1c Poor Control (>9.0%)**	83.2%	45.26%	75.3%	48.91%
Eye Exam for Patients with Diabetes (EED)	19.9%	33.33%	31.6%	38.69%
BP Control for Patients with Diabetes (BPD)	25.9%	61.31%	48.6%	53.53%
Kidney Health Evaluation for Patients with Diabetes (KED): Total				
18 Years–64 Years	—	—	14.1%	17.81%
65 Years–74 Years	—	—	13.9%	17.48%
75 Years–85 Years	—	—	15.4%	19.10%
Total	12.7%	18.55%	—	17.85%
Effectiveness of Care: Behavioral Health				
Diagnosed Mental Health Disorders (DMH)				
1 Years–17 Years	—	—	16.4%	18.06%
18 Years–64 Years	—	—	15.8%	17.50%
65+ Years	—	—	20.1%	22.66%
Total	12.0%	14.01%	—	17.91%
Diagnosed Substance Use Disorders (DSU)				
Alcohol				
13 Years–17 Years	—	—	0.0%	—
18 Years–64 Years	—	—	0.6%	—
65+ Years	—	—	1.0%	—
Total	0.2%	0.53%	—	0.70%

** NCQA national average was not available for comparison.

HEDIS MY 2022	FMHP	MMM	PSM	Triple S
Any				
13 Years–17 Years	—	—	0.2%	—
18 Years–64 Years	—	—	1.9%	—
65+ Years	—	—	2.0%	—
Total	0.9%	0.51%	—	2.11%
Opioid				
13 Years–17 Years	—	—	0.0%	—
18 Years–64 Years	—	—	0.6%	—
65+ Years	—	—	0.2%	—
Total	0.4%	0.95%	—	0.59%
Other				
13 Years–17 Years	—	—	0.1%	—
18 Years–64 Years	—	—	1.2%	—
65+ Years	—	—	0.9%	—
Total	0.4%	1.54%	—	1.37%
Antidepressant Medication Management (AMM)				
Acute	31.4%	49.09%	60.0%	49.64%
Continuation	12.6%	32.93%	44.8%	33.63%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation	64.4%	67.14%	47.7%	48.33%
Continuation	NA	85.85%	52.4%	65.05%
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
Follow-Up 7 Days				
13 Years–17 Years	0.0%	—	0.0%	16.67%
18 Years–64 Years	10.4%	—	24.3%	18.28%
Total	—	14.29%	—	18.25%
Follow-Up 30 Days				

HEDIS MY 2022	FMHP	MMM	PSM	Triple S
13 Years–17 Years	0.0%	—	0.0%	25.00%
18 Years–64 Years	20.2%	—	36.1%	34.95%
Total	—	28.38%	—	34.76%
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up				
6 Years–17 Years	26.0%	—	53.3%	36.49%
18 Years–64 Years	27.8%	—	43.3%	29.27%
65+ Years	12.1%	—	17.4%	20.97%
Total	—	23.04%	—	30.17%
30-Day Follow-Up				
6 Years–17 Years	49.5%	—	85.4%	69.64%
18 Years–64 Years	51.0%	—	74.8%	61.99%
65+ Years	42.4%	—	56.5%	54.84%
Total	—	68.85%	—	62.99%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up				
6 Years–17 Years	32.6%	—	34.4%	43.18%
18 Years–64 Years	30.9%	—	31.5%	42.70%
65+ Years	41.0%	—	37.5%	31.82%
Total	—	33.05%	—	42.14%
30-Day Follow-Up				
6 Years–17 Years	68.6%	—	71.9%	79.55%
18 Years–64 Years	51.8%	—	50.7%	63.20%
65+ Years	51.3%	—	68.8%	59.09%
Total	—	55.37%	—	64.82%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	0.0%	72.98%	71.3%	73.16%

HEDIS MY 2022	FMHP	MMM	PSM	Triple S
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	53.9%	67.50%	66.1%	63.82%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose Testing				
3 Years–11 Years	49.8%	—	63.2%	56.39%
12 Years–17 Years	56.1%	—	62.7%	60.79%
Total	—	61.34%	—	58.91%
Cholesterol Testing:				
3 Years–11 Years	42.3%	—	44.5%	45.03%
12 Years–17 Years	51.2%	—	50.8%	52.58%
Total	—	51.79%	—	49.35%
Blood Glucose and Cholesterol Testing				
3 Years–11 Years	41.9%	—	44.0%	43.61%
12 Years–17 Years	49.5%	—	49.2%	51.52%
Total	—	50.95%	—	48.13%
Effectiveness of Care: Overuse/Appropriateness				
Appropriate Treatment for Upper Respiratory Infection (URI)				
3 Months–17 Years	—	—	26.0%	72.38%
18 Years–64 Years	—	—	43.1%	58.05%
65+ Years	—	—	35.8%	61.29%
Total	22.0%	64.87%	—	66.04%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB):				
3 Months–17 Years	20.4%	—	39.1%	62.75%
18 Years–64 Years	39.4%	—	54.9%	49.43%
65+ Years	43.2%	—	55.8%	48.96%
Total	—	54.60%	—	57.35%

HEDIS MY 2022	FMHP	MMM	PSM	Triple S
Access/Availability of Care				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (AAP)				
1 Years–11 Years	65.1%	—	47.5%	60.33%
12 Years–17 Years	58.3%	—	50.0%	60.90%
Total	—	35.64%	—	60.63%
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	45.1%	66.42%	41.7%	84.37%
Postpartum Care	21.8%	56.93%	31.2%	49.60%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation: Alcohol				
13 Years–17 Years	0.0%	—	NA	—
18 Years–64 Years	64.1%	—	32.2%	—
65+ Years	62.5%	—	17.2%	—
Total	—	—	—	29.54%
Initiation: Opioid				
13 Years–17 Years	0.0%	—	NA	—
18 Years–64 Years	89.1%	—	46.2%	—
65+ Years	100.0%	—	25.0%	—
Total	—	—	—	51.17%
Initiation: Other				
13 Years–17 Years	80.0%	—	NA	—
18 Years–64 Years	78.4%	—	32.4%	—
65+ Years	88.9%	—	7.1%	—
Total	—	—	—	30.12%
Initiation: Total	—	45.27%	—	—
Engagement: Alcohol				
13 Years–17 Years	0.0%	—	NA	—

HEDIS MY 2022	FMHP	MMM	PSM	Triple S
18 Years–64 Years	6.3%	—	7.5%	—
65+ Years	8.3%	—	2.3%	—
Total	—	—	—	6.76%
Engagement: Opioid				
13 Years–17 Years	0.0%	—	NA	—
18 Years–64 Years	18.6%	—	17.0%	—
65+ Years	0.0%	—	16.7%	—
Total	—	—	—	17.83%
Engagement: Other				
13 Years–17 Years	10.0%	—	NA	—
18 Years–64 Years	8.4%	—	8.5%	—
65+ Years	0.0%	—	2.4%	—
Total	—		—	7.63%
Engagement: Total	—	11.06%	—	—
Utilization and Risk Adjusted Utilization				
Well-Child Visits in the First 30 Months of Life (W30)				
Age 15 Months	1.6%	11.67%	10.4%	6.74%
Age 15 Months–30 Months	12.9%	44.15%	40.1%	36.34%
Child Adolescent Well Visits (WCV)				
3 Years–11 Years	17.5%	—	42.7%	46.13%
12 Years–17 Years	14.3%	—	34.9%	38.92%
18 Years–21 Years	7.2%	—	25.1%	25.75%
Total	—	42.99%	—	39.05%

Appendix D
Platino Reported PM Rates

Introduction

PM rate reporting for CYs 2019–2022 and comparison to National Benchmark.

MAOs were required to report their CYs 2019–2022 HEDIS measure rates. The MAO reports were compiled and comparative results between MAOs and relative to national benchmarks are included. Comparison is made with NCQA national average category “All LOBs Excluding PPOs and EPOs”. If a lower rate is desirable, it is noted in the table. If a measure met or scored better than the National Average, it is reported in green. CMS suspended data reporting for Medicare during the COVID-19 PHE; therefore, national averages are not available for NCQA HEDIS MY 2019. Mercer compiled the reported annual HEDIS rates by year for the MAO plans below.

Humana

HEDIS MY 2019 Rates

HEDIS MY 2019	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (ABA): Total	99.27%	—	—
Breast Cancer Screening (BCS): Total	83.36%	—	—
Colorectal Cancer Screening (COL): Total	88.08%	88.83%	89.11%
Care for Older Adults (COA)			
Advance Care Planning	78.05%	78.10%	81.75%
Medication Review	91.96%	96.59%	98.30%
Functional Status Assessment	93.04%	97.10%	96.73%
Pain Assessment	92.07%	97.81%	97.57%
Effectiveness of Care: Respiratory Conditions			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	30.70%	30.36%	29.90%
Pharmacotherapy Management of COPD Exacerbation (PCE)			

HEDIS MY 2019	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018
Systemic Corticosteroid	37.92%	44.28%	34.03%
Bronchodilator	78.27%	80.10%	81.15%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)	86.86%	74.68%	75.93%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	74.77%	76.74%	71.05%
Statin Therapy for Patients with Cardiovascular Disease (SPC)			
Received Statin Therapy: Total	83.89%	—	—
Statin Adherence 80%: Total	72.48%	—	—
Statin Therapy for Patients with Diabetes (SPD)			
Received Statin Therapy	81.90%	—	—
Statin Adherence 80%	69.33%	—	—
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (CDC)			
Hemoglobin A1c (HbA1c) Testing	95.86%	—	—
HbA1c Poor Control (>9.0%)	15.33%	—	—
HbA1c Control (<8.0%)	62.53%	—	—
Medical Attention for Nephropathy	99.27%	—	—
Blood Pressure Control (<140/90 mm Hg)	82.97%	—	—
Eye Exam: Total	82.00%	—	—
Effectiveness of Care: Musculoskeletal Conditions			
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)	75.89%	—	—
Osteoporosis Management in Women Who Had a Fracture (OMW)	40.00%	38.46%	50%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (AMM)			

HEDIS MY 2019	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018
Effective Acute Phase Treatment	52.49%	55.56%	53.67%
Effective Continuation Phase Treatment	31.70%	31.81%	34.17%
Follow-Up After Hospitalization for Mental Illness (FUH)			
Total: 30-Day Follow-Up	25.00%	33.33%	0%
Total: 7-Day Follow-Up	0.00%	0.00%	0%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
Total: 30-Day Follow-Up	55.95%	—	—
Total: 7-Day Follow-Up	14.29%	—	—
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)			
Total: 30-Day Follow-Up	17.39%	—	—
Total: 7-Day Follow-Up	8.70%	—	—
Effectiveness of Care: Medication Management			
Medication Reconciliation Post-Discharge (MRP)	74.94%	58.64%	57.60%
Transition of Care (TRC)			
Notification of Inpatient Admission: Total	0.00%	—	—
Receipt of Discharge Information: Total	0.24%	—	—
Patient Engagement After Inpatient Discharge	83.45%	81.48%	83.74%
Medication Reconciliation Post-Discharge	56.69%	58.64%	57.60%
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)			
7-Day Follow-After the ED Visit: Total	44.39%	—	—
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended PSA-Based Screening in Older Men (PSA)	66.32%	—	—

HEDIS MY 2019	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)			
Falls + Anticonvulsants, Nonbenzodiazepine Hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines, or Tricyclic Antidepressants	55.29%	58.04%	55.26%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine Hypnotics, or Anticholinergic Agents	70.62%	73.49%	78.20%
Chronic Kidney Disease + Cox-2 Selective NSAIDs or Non-Aspirin NSAIDs	28.39%	35.12%	26.45%
Total	58.00%	60.79%	61.29%
Use of High-Risk Medications in the Elderly (DAE)			
One Prescription	20.95%	23.18%	25.44%
At Least Two Prescriptions	11.17%	13.31%	13.96%
Use of Opioids at High Dosage (UOD)	0.28%	—	—
Use of Opioids from Multiple Providers (UOP)			
Multiple Prescribers	3.81%	—	—
Multiple Pharmacies	7.02%	—	—
Multiple Prescribers and Multiple Pharmacies	1.49%	—	—
Risk of Continued Opioid Use (COU)			
Total: >=15 Days Covered	45.57%	—	—
Total: >=31 Days Covered	6.92%	—	—
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP): Total	97.91%	—	—
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)			

HEDIS MY 2019	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018
Initiation of AOD Treatment: Total	10.00%	—	—
Engagement of AOD Treatment: Total	0.59%	—	—
Utilization			
Ambulatory Care (AMBA)			
Outpatient Visits/1,000 Member Years	11,194.63	—	—
ED Visits/1,000 Member Years	885.71	—	—
Inpatient Utilization — General Hospital/Acute Care (IPUA)			
Total Inpatient Discharges/1,000 Member Years	160.95	—	—
Total Inpatient Days/1,000 Member Years	1119.59	—	—
Total Maternity Discharges/1,000 Member Years	0.63	—	—
Total Maternity Days/1,000 Member Years	1.47	—	—
Total Surgery Discharges/1,000 Member Years	29.42	—	—
Total Surgery Days/1,000 Member Years	240.11	—	—
Total Medicine Discharges/1,000 Member Years	131.35	—	—
Total Medicine Days/1,000 Member Years	879.05	—	—
Identification of Alcohol and Other Drug Services (IADA)			
Any Services, Percentage	22.39%	—	—
Inpatient, Percentage	0.25%	—	—
IOP/PH, Percentage	0.00%	—	—
Outpatient Mediation Treatment, Percentage	22.10%	—	—
ED, Percentage	0.24%	—	—
Telehealth, Percentage	0.00%	—	—
Mental Health Utilization (MPTA)			

HEDIS MY 2019	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018
Any Services, Percentage	23.49%	—	—
Inpatient, Percentage	0.01%	—	—
IOP/PH, Percentage	0.00%	—	—
Outpatient Mediation Treatment, Percentage	23.21%	—	—
ED, Percentage	0.57%	—	—
Telehealth, Percentage	0.04%	—	—
Risk Adjusted Utilization			
Plan All-Cause Readmissions (PCR)			
Total Observed Readmission Rate	11.66%	12.24%	11.18%
Plan All-Cause Readmissions Part-B (PCRB)			
Total Observed Readmission Rate	13.30%	14.93%	9.64%
Hospitalization Following Discharge from a Skilled Nursing Facility (HFS)			
30-Day Hospitalization Following D/C, Observed Hospitalization Rate	1.96%	—	—
60-Day Hospitalization Following D/C, Observed Hospitalization Rate	9.80%	—	—
Acute Hospital Utilization (AHU)			
Surgery: Observed Discharge/1,000 Members	26.09	—	—
Medicine: Observed Discharge/1,000 Members	110.87	—	—
Total: Observed Discharge/1,000 Members	136.96	—	—
Emergency Department Utilization (EDU)			
Observed Discharge/1,000 Members	812.62	—	—
Hospitalization for Potentially Preventable Complications (HPC)			
Observed Discharge/1,000 Members	29.37	—	—
Board Certification (BCR)			

HEDIS MY 2019	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018
Family Medicine	41.21%	41.21%	41.21%
Internal Medicine	53.04%	53.04%	53.04%
Pediatricians	40.52%	40.52%	40.52%
OB/GYN Physicians	41.58%	41.58%	41.58%
Geriatricians	23.08%	23.08%	23.08%
Other Physician Specialists	63.31%	63.31%	63.31%

HEDIS MY 2020 Rates

HEDIS MY 2020	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (ABA)	98.78%	—	—
Breast Cancer Screening (BCS): Total	87.59%	—	—
Colorectal Cancer Screening (COL): Total**	92.46%	89.62%	89.54%
Care for Older Adults (COA)**			
Advance Care Planning	72.85%	75.18%	75.43%
Medication Review	90.49%	97.81%	96.84%
Functional Status Assessment	91.14%	96.59%	95.62%
Pain Assessment	92.46%	98.78%	97.57%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for pharyngitis (CWP)	1.18%	—	—
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	34.12%	35.05%	35.05%
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Systemic Corticosteroid	44.84%	48.95%	37.11%

**NCQA national average was not available for comparison.

HEDIS MY 2020	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018
Bronchodilator	80.82%	83.92%	82.99%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)	85.51%	76.26%	77.20%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	83.02%	95.00%	76.92%
Statin Therapy for Patients with Cardiovascular Disease (SPC)			
Received Statin Therapy: Total	87.77%	—	—
Statin Adherence 80%: Total	74.12%	—	—
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (CDC)			
Hemoglobin A1c (HbA1c) Testing	95.62%	—	—
HbA1c Poor Control (>9.0%)*	18.25%	—	—
HbA1c Control (<8.0%)	65.45%	—	—
Medical Attention for Nephropathy	99.51%	—	—
Blood Pressure Control (<140/90 mm Hg)	84.18%	—	—
Eye Exam: Total	91.00%	—	—
Statin Therapy for Patients with Diabetes (SPD)			
Received Statin Therapy	81.75%	—	—
Statin Adherence 80%	72.95%	—	—
Effectiveness of Care: Musculoskeletal Conditions			
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)**	76.29%	—	—
Osteoporosis Management in Women Who Had a Fracture (OMW)**	75.00%	81.82%	72.73%
Effectiveness of Care: Behavioral Health			

* For this measure, a lower rate indicates better performance.

** NCQA national average was not available for comparison.

HEDIS MY 2020	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018
Antidepressant Medication Management (AMM)			
Effective Acute Phase Treatment	59.82%	64.48%	59.26%
Effective Continuation Phase Treatment	42.11%	46.14%	42.28%
Follow-Up After Hospitalization for Mental Illness (FUH)			
Total: 30-Day Follow-Up	64.75%	67.86%	66.67%
Total: 7-Day Follow-Up	38.52%	42.86%	39.39%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
Total: 30-Day Follow-Up	63.95%	—	—
Total: 7-Day Follow-Up	16.28%	—	—
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)			
Total: 30-Day Follow-Up	22.73%	—	—
Total: 7-Day Follow-Up	4.55%	—	—
Effectiveness of Care: Medication Management			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	72.95%	—	—
Medication Reconciliation Post-Discharge (MRP)**	81.51%	72.97%	71.25%
Transition of Care (TRC)**			
Notification of Inpatient Admission: Total	0.24%	0.24%	0.00%
Receipt of Discharge Information: Total	0.73%	0.49%	0.24%
Patient Engagement After Inpatient Discharge	83.13%	84.18%	81.27%
Medication Reconciliation Post-Discharge	72.51%	72.75%	70.07%

** NCQA national average was not available for comparison.

HEDIS MY 2020	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)**			
7-Day Follow-After the ED Visit: Total	46.48%	—	—
Effectiveness of Care: Overuse/Appropriateness			
Appropriate Treatment for Upper Respiratory Infection (URI): Total	52.34%	—	—
Non-Recommended PSA-Based Screening in Older Men (PSA)**	64.66%	—	—
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB): Total	40.14%	—	—
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)**			
Falls + Anticonvulsants, Nonbenzodiazepine Hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines, or Tricyclic Antidepressants	47.09%	54.55%	45.92%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine Hypnotics, or Anticholinergic Agents	69.05%	72.69%	75.85%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-Aspirin NSAIDs	25.70%	28.08%	25.50%
Total	54.40%	57.84%	56.31%
Use of High-Risk Medications in the Elderly (DAE)**	16.92%	18.02%	20.19%
Use of Opioids from Multiple Providers (UOP)*			
Multiple Prescribers	3.66%	—	—
Multiple Pharmacies	6.91%	—	—

** NCQA national average was not available for comparison.

* For this measure, a lower rate indicates better performance.

HEDIS MY 2020	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018
Multiple Prescribers and Multiple Pharmacies	0.92%	—	—
Risk of Continued Opioid Use (COU)*			
Total: >=15 Days Covered	15.21%	—	—
Total: >=31 Days Covered	3.62%	—	—
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP): Total	97.97%	—	—
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)			
Initiation of AOD Treatment: Total	5.33%	—	—
Engagement of AOD Treatment: Total	0.37%	—	—
Utilization			
Frequency of Selected Procedures (FSP)*			
Bariatric Weight Loss Surgery Total Procedures/1,000 Member Years	1.29	—	—
CABG Total Procedures/1,000 Member Years**	9.83	—	—
PCI Total Procedures/1,000 member Years**	57.04	—	—
Cardiac Catheterization Total Procedures/1,000 Member Years**	137.87	—	—
Carotid Endarterectomy Total Procedures/1,000 Member Years**	3.30	—	—
Cholecystectomy, Laparoscopic Total Procedures/1,000 Member Years	7.44	—	—
Cholecystectomy, Closed Total Procedures/1,000 Member Years	33.02	—	—
Back Surgery Total Procedures/1,000 Member Years	19.28	—	—

* For this measure, a lower rate indicates better performance.

** NCQA national average was not available for comparison.

HEDIS MY 2020	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018
Hysterectomy, Abdominal Total Procedures/1,000 Member Years	7.76	—	—
Hysterectomy, Vaginal Total Procedures/1,000 Member Years	3.34	—	—
Prostatectomy Total Procedures/1,000 Member Years**	21.49	—	—
Total Hip Replacement Total Procedures/1,000 Member Years**	13.70	—	—
Total Knee Replacement Total Procedures/1,000 Member Years**	35.22	—	—
Mastectomy Total Procedures/1,000 Member Years	3.74	—	—
Lumpectomy Total Procedures/1,000 Member Years	13.52	—	—
Identification of Alcohol and Other Drug Services (IADA)**			
Any Services, Percentage	20.64%	—	—
Inpatient, Percentage	0.28%	—	—
IOP/PH, Percentage	0.01%	—	—
Outpatient Mediation Treatment, Percentage	20.31%	—	—
ED, Percentage	0.25%	—	—
Telehealth, Percentage	0.03%	—	—
Mental Health Utilization (MPTA)**			
Any Services, Percentage	25.40%	—	—
Inpatient, Percentage	0.38%	—	—
IOP/PH, Percentage	0.28%	—	—
Outpatient Mediation Treatment, Percentage	25.32%	—	—
ED, Percentage	0.06%	—	—

** NCQA national average was not available for comparison.

HEDIS MY 2020	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018
Telehealth, Percentage	0.13%	—	—
Risk Adjusted Utilization			
Plan All-Cause Readmissions (PCR)**			
Total Observed Readmission Rate	11.50%	13.54%	10.81%
Hospitalization Following Discharge from a Skilled Nursing Facility (HFS)**			
30-Day Hospitalization Following D/C, Observed Hospitalization Rate	7.21%	—	—
60-Day Hospitalization Following D/C, Observed Hospitalization Rate	10.81%	—	—
Acute Hospital Utilization (AHU)**			
Surgery: Observed Discharge/1,000 Members	23.73	—	—
Medicine: Observed Discharge/1,000 Members	111.27	—	—
Total: Observed Discharge 1,000 Members	135.01	—	—
Emergency Department Utilization (EDU)**			
Observed Discharge/1,000 Members	923.77	—	—
Hospitalization for Potentially Preventable Complications (HPC)**			
Observed Discharge/1,000 Members	32.14	—	—

HEDIS 2021 Rates

HEDIS 2021	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019
Effectiveness of Care: Prevention and Screening				
Breast Cancer Screening (BCS): Total	82.91%	—	—	—

** NCQA national average was not available for comparison.

HEDIS 2021	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019
Colorectal Cancer Screening (COL): Total**	88.32%	87.20%	87.40%	84.98%
Care for Older Adults (COA)**				
Advance Care Planning	64.14%	63.99%	62.77%	64.23%
Medication Review	77.90%	90.02%	91.24%	90.75%
Functional Status Assessment	79.36%	81.52%	84.84%	85.37%
Pain Assessment	86.50%	95.62%	98.05%	97.81%
Effectiveness of Care: Respiratory Conditions				
Appropriate Testing for pharyngitis (CWP)	0.25%	—	—	—
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	29.62%	27.18%	33.63%	28.57%
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Systemic Corticosteroid	48.21%	36.59%	48.00%	50.00%
Bronchodilator	80.51%	78.05%	82.00%	80.00%
Effectiveness of Care: Cardiovascular Conditions				
Controlling High Blood Pressure (CBP)	80.78%	71.64%	75.25%	76.47%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	82.61%	75.00%	86.36%	100.00%
Statin Therapy for Patients with Cardiovascular Disease (SPC)				
Received Statin Therapy: Total	88.65%	—	—	—
Statin Adherence 80%: Total	78.93%	—	—	—
Cardiac Rehabilitation (CRE)**	0.00%	—	—	—
Effectiveness of Care: Diabetes				
Comprehensive Diabetes Care (CDC)				
Hemoglobin A1c (HbA1c) Testing	93.19%	—	—	—

** NCQA national average was not available for comparison.

HEDIS 2021	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019
HbA1c Poor Control (>9.0%)*	17.76%	—	—	—
HbA1c Control (<8.0%)	72.02%	—	—	—
Medical Attention for Nephropathy**	98.78%	—	—	—
Blood Pressure Control (<140/90 mm Hg)	80.29%	—	—	—
Eye Exam: Total	80.29%	—	—	—
Kidney Health Evaluation for Patients with Diabetes (KED): Total**	23.78%	—	—	—
Statin Therapy for Patients with Diabetes (SPD)				
Received Statin Therapy	81.70%	—	—	—
Statin Adherence 80%	76.99%	—	—	—
Effectiveness of Care: Musculoskeletal Conditions				
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)**	81.51%	—	—	—
Osteoporosis Management in Women Who Had a Fracture (OMW)**	67.50%	42.86%	76.92%	50.00%
Osteoporosis Screening in Older Women (OSW)**	62.32%	—	—	—
Effectiveness of Care: Behavioral Health				
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	65.35%	67.92%	65.65%	71.23%
Effective Continuation Phase Treatment	44.96%	47.17%	45.91%	53.42%
Follow-Up After Hospitalization for Mental Illness (FUH)				
Total: 30-Day Follow-Up	53.95%	37.50%	63.33%	80.00%

* For this measure, a lower rate indicates better performance.

** NCQA national average was not available for comparison.

HEDIS 2021	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019
Total: 7-Day Follow-Up	36.84%	16.67%	53.33%	80.00%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
Total: 30-Day Follow-Up	50.00%	—	—	—
Total: 7-Day Follow-Up	17.74%	—	—	—
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)				
30-Day Follow-Up: Total	25.00%	—	—	—
7-Day Follow-Up: Total	0.00%	—	—	—
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)				
Total: 30-Day Follow-Up	19.05%	—	—	—
Total: 7-Day Follow-Up	14.29%	—	—	—
Effectiveness of Care: Medication Management				
Pharmacotherapy for Opioid Use Disorder (POD): Total	50.00%	—	—	—
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	71.30%	—	—	—
Transition of Care (TRC)**				
Notification of Inpatient Admission: Total	0.24%	0.00%	0.24%	0.00%
Receipt of Discharge Information: Total	0.97%	0.00%	0.49%	0.00%
Patient Engagement After Inpatient Discharge	81.27%	77.13%	80.78%	80.49%
Medication Reconciliation Post-Discharge	79.32%	70.56%	74.45%	64.02%

** NCQA national average was not available for comparison.

HEDIS 2021	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)**				
7-Day Follow-After the ED Visit: Total	47.49%	—	—	—
Effectiveness of Care: Overuse/Appropriateness				
Non-Recommended PSA-Based Screening in Older Men (PSA)**	59.02%	—	—	—
Appropriate Treatment for Upper Respiratory Infection (URI): Total	51.09%	—	—	—
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	39.39%	—	—	—
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)**				
Falls + Anticonvulsants, Nonbenzodiazepine Hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines, or Tricyclic Antidepressants	50.52%	52.74%	54.74%	57.14%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine Hypnotics, or Anticholinergic Agents	50.53%	53.30%	52.83%	51.85%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-Aspirin NSAIDs	26.75%	22.85%	31.43%	40.00%
Total	44.88%	45.29%	47.89%	50.00%
Use of High-Risk Medications in the Elderly (DAE)**	24.82%	27.15%	28.26%	27.14%
Use of Opioids from Multiple Providers (UOP)*				

** NCQA national average was not available for comparison.

* For this measure, a lower rate indicates better performance.

HEDIS 2021	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019
Multiple Prescribers	2.18%	—	—	—
Multiple Pharmacies	6.62%	—	—	—
Multiple Prescribers and Multiple Pharmacies	0.48%	—	—	—
Risk of Continued Opioid Use (COU)*				
Total: >=15 Days Covered	13.05%	—	—	—
Total: >=31 Days Covered	3.31%	—	—	—
Access/Availability of Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP): Total	97.36%	—	—	—
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)				
Initiation of AOD Treatment: Total	21.64%	—	—	—
Engagement of AOD Treatment: Total	1.56%	—	—	—
Utilization				
Frequency of Selected Procedures (FSP)*				
Bariatric Weight Loss Surgery Total Procedures/1,000 Member Years	1.85	—	—	—
CABG Total Procedures/1,000 Member Years**	5.76	—	—	—
PCI Total Procedures/1,000 Member Years**	51.04	—	—	—
Cardiac Catheterization Total Procedures/1,000 Member Years**	108.52	—	—	—
Carotid Endarterectomy Total Procedures/1,000 Member Years**	1.45	—	—	—

* For this measure, a lower rate indicates better performance.

** NCQA national average was not available for comparison.

HEDIS 2021	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019
Cholecystectomy, Open Total Procedures/1,000 Member Years**	7.19	—	—	—
Cholecystectomy, Closed Total Procedures/1,000 Member Years**	24.77	—	—	—
Back Surgery Total Procedures/1,000 Member Years	19.26	—	—	—
Hysterectomy, Abdominal Total Procedures/1,000 Member Years	4.66	—	—	—
Hysterectomy, Vaginal Total Procedures/1,000 Member Years	4.98	—	—	—
Prostatectomy Total Procedures/1,000 Member Years**	18.11	—	—	—
Total Hip Replacement Total Procedures/1,000 Member Years**	9.37	—	—	—
Total Knee Replacement Total Procedures/1,000 Member Years**	25.64	—	—	—
Mastectomy Total Procedures/1,000 Member Years	4.75	—	—	—
Lumpectomy Total Procedures/1,000 Member Years	10.09	—	—	—
Identification of Alcohol and Other Drug Services (IADA)**				
Any Services, Percentage	18.93%	—	—	—
Inpatient, Percentage	0.21%	—	—	—
IOP/PH, Percentage	0.00%	—	—	—
Outpatient Mediation Treatment, Percentage	17.23%	—	—	—
ED, Percentage	0.21%	—	—	—
Telehealth, Percentage	4.66%	—	—	—
Mental Health Utilization (MPTA)**				
Any Services, Percentage	23.82%	—	—	—

** NCQA national average was not available for comparison.

HEDIS 2021	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019
Inpatient, Percentage	0.28%	—	—	—
IOP/PH, Percentage	0.15%	—	—	—
Outpatient Mediation Treatment, Percentage	20.73%	—	—	—
ED, Percentage	0.13%	—	—	—
Telehealth, Percentage	8.63%	—	—	—
Risk Adjusted Utilization				
Hospitalization Following Discharge from a Skilled Nursing Facility (HFS)**				
30-Day Hospitalization Following D/C, Observed Hospitalization Rate	4.69%	—	—	—
60-Day Hospitalization Following D/C, Observed Hospitalization Rate	6.25%	—	—	—
Acute Hospital Utilization (AHU)**				
Surgery: Observed Discharge/1,000 Members	24.79	—	—	—
Medicine: Observed Discharge/1,000 Members	89.87	—	—	—
Total: Observed Discharge/1,000 Members	114.66	—	—	—
Emergency Department Utilization (EDU)**				
Observed Discharge/1,000 Members	450.19	—	—	—
Hospitalization for Potentially Preventable Complications (HPC)**				
Observed Discharge/1,000 Members	23.06	—	—	—

** NCQA national average was not available for comparison.

HEDIS MY 2022 Rates

HEDIS MY 2022	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019	Humana Health, Plan ID 022
Effectiveness of Care: Prevention and Screening					
Breast Cancer Screening (BCS): Total	84.37%	—	—	—	—
Colorectal Cancer Screening (COL): Total**	86.62%	88.12%	88.80%	87.50%	86.31%
Care for Older Adults (COA)**					
Advance Care Planning	—	66.91%	69.83%	74.70%	66.18%
Medication Review	—	96.59%	97.57%	95.62%	94.89%
Functional Status Assessment	—	96.11%	96.56%	97.08%	95.62%
Pain Assessment	—	98.30%	99.03%	98.30%	98.30%
Effectiveness of Care: Respiratory Conditions					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	31.10%	31.53%	30.91%	27.59%	27.27%
Pharmacotherapy Management of COPD Exacerbation (PCE)					
Systemic Corticosteroid	41.51%	36.84%	42.22%	45.45%	0.00%
Bronchodilator	85.85%	78.95%	97.78%	90.91%	0.00%
Effectiveness of Care: Cardiovascular Conditions					
Controlling High Blood Pressure (CBP)	86.13%	77.69%	80.48%	80.00%	79.83%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	79.55%	90.00%	77.27%	100.00%	100.00%
Statin Therapy for Patients with Cardiovascular Disease (SPC)					
Received Statin Therapy: Total	90.45%	—	—	—	—

** NCQA national average was not available for comparison.

HEDIS MY 2022	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019	Humana Health, Plan ID 022
Statin Adherence 80%: Total	79.88%	—	—	—	—
Effectiveness of Care: Diabetes					
Comprehensive Diabetes Care (CDC)					
Hemoglobin A1c (HbA1c) Testing	96.11%	—	—	—	—
HbA1c Poor Control (>9.0%)*	12.65%	—	—	—	—
HbA1c Control (<8.0%)	76.40%	—	—	—	—
Medical Attention for Nephropathy**	99.76%	—	—	—	—
Blood Pressure Control (<140/90 mm Hg)	82.00%	—	—	—	—
Eye Exam: Total	80.05%	—	—	—	—
Statin Therapy for Patients with Diabetes (SPD)					
Received Statin Therapy	85.82%	—	—	—	—
Statin Adherence 80%	79.78%	—	—	—	—
Effectiveness of Care: Musculoskeletal Conditions					
Osteoporosis Management in Women Who Had a Fracture (OMW)**	69.23%	72.73%	77.78%	100.00%	—
Osteoporosis Screening in Older Women (OSW)**	64.95%	—	—	—	—
Effectiveness of Care: Behavioral Health					
Antidepressant Medication Management (AMM)					
Effective Acute Phase Treatment	64.19%	67.27%	61.60%	65.06%	65.22%
Effective Continuation Phase Treatment	45.27%	50.91%	41.87%	43.37%	50.00%

* For this measure, a lower rate indicates better performance.

** NCQA national average was not available for comparison.

HEDIS MY 2022	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019	Humana Health, Plan ID 022
Follow-Up After Hospitalization for Mental Illness (FUH)					
Total: 30-Day Follow-Up	79.53%	91.67%	75.00%	73.33%	77.78%
Total: 7-Day Follow-Up	54.97%	70.83%	45.59%	66.67%	61.11%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					
Total: 30-Day Follow-Up	40.91%	—	—	—	—
Total: 7-Day Follow-Up	22.73%	—	—	—	—
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)					
Total: 30-Day Follow-Up	46.43%	—	—	—	—
Total: 7-Day Follow-Up	25.00%	—	—	—	—
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)					
Total: 30-Day Follow-Up	0.00%	—	—	—	—
Total: 7-Day Follow-Up	0.00%	—	—	—	—
Effectiveness of Care: Medication Management					
Transition of Care (TRC)**					
Notification of Inpatient Admission: Total	0.73%	0.00%	0.49%	0.00%	0.00%
Receipt of Discharge Information: Total	1.22%	0.24%	0.24%	0.00%	0.95%
Patient Engagement After Inpatient Discharge	78.83%	81.02%	81.02%	80.87%	78.10%

** NCQA national average was not available for comparison.

HEDIS MY 2022	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019	Humana Health, Plan ID 022
Medication Reconciliation Post-Discharge	83.94%	78.10%	79.81%	77.26%	66.67%
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)**					
7-Day Follow-After the ED Visit: Total	46.96%	—	—	—	—
Effectiveness of Care: Overuse/Appropriateness					
Non-Recommended PSA-Based Screening in Older Men (PSA)**	65.12%	—	—	—	—
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)**					
Falls + Anticonvulsants, Nonbenzodiazepine Hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines, or Tricyclic Antidepressants	48.48%	49.61%	55.11%	56.82%	40.00%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine Hypnotics, or Anticholinergic Agents	48.88%	48.86%	51.54%	50.00%	78.57%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-Aspirin NSAIDs	25.27%	25.59%	26.45%	25.76%	44.83%
Total	42.82%	42.65%	45.74%	44.35%	60.47%
Use of High-Risk Medications in the Elderly (DAE): Total**	25.62%	27.48%	29.36%	29.66%	24.48%

** NCQA national average was not available for comparison.

HEDIS MY 2022	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019	Humana Health, Plan ID 022
Use of Opioids at High Dosage (HDO)*	0.35%	—	—	—	—
Use of Opioids from Multiple Providers (UOP)*					
Multiple Prescribers	2.38%	—	—	—	—
Multiple Pharmacies	6.18%	—	—	—	—
Multiple Prescribers and Multiple Pharmacies	0.10%	—	—	—	—
Risk of Continued Opioid Use (COU)*					
Total: >=15 Days Covered	12.53%	—	—	—	—
Total: >=31 Days Covered	4.62%	—	—	—	—
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP): Total	97.90%				
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)					
Initiation of AOD Treatment: Total	28.22%	—	—	—	—
Engagement of AOD Treatment: Total	1.27%	—	—	—	—
Utilization					
Frequency of Selected Procedures (FSP)*					
Bariatric Weight Loss Surgery Total Procedures/1,000 Member Years	0.91	—	—	—	—

* For this measure, a lower rate indicates better performance.

HEDIS MY 2022	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019	Humana Health, Plan ID 022
CABG Total Procedures/1,000 Member Years**	9.59	—	—	—	—
PCI Total Procedures/1,000 Member Years**	49.58	—	—	—	—
Cardiac Catheterization Total Procedures/1,000 Member Years**	148.78	—	—	—	—
Carotid Endarterectomy Total Procedures/1,000 Member Years**	1.58	—	—	—	—
Cholecystectomy, Open Total Procedures/1,000 Member Years	7.62	—	—	—	—
Cholecystectomy, Laparoscopic Total Procedures/1,000 Member Years	28.80	—	—	—	—
Back Surgery Total Procedures/1,000 Member Years	22.09	—	—	—	—
Hysterectomy, Abdominal Total Procedures/1,000 Member Years	8.03	—	—	—	—
Hysterectomy, Vaginal Total Procedures/1,000 Member Years	3.85	—	—	—	—
Prostatectomy Total Procedures/1,000 Member Years**	19.25	—	—	—	—
Total Hip Replacement Total Procedures/1,000 Member Years**	12.38	—	—	—	—

** NCQA national average was not available for comparison.

* For this measure, a lower rate indicates better performance.

HEDIS MY 2022	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019	Humana Health, Plan ID 022
Total Knee Replacement Total Procedures/1,000 Member Years**	38.49	—	—	—	—
Mastectomy Total Procedures/1,000 Member Years	4.83	—	—	—	—
Lumpectomy Total Procedures/1,000 Member Years	13.51	—	—	—	—
Identification of Alcohol and Other Drug Services (IADA)**					
Any Services, Percentage	19.63%	—	—	—	—
Inpatient, Percentage	0.40%	—	—	—	—
IOP/PH, Percentage	0.01%	—	—	—	—
Outpatient Mediation Treatment, Percentage	18.10%	—	—	—	—
ED, Percentage	0.18%	—	—	—	—
Telehealth, Percentage	2.99%	—	—	—	—
Mental Health Utilization (MPTA)**					
Any Services, Percentage	22.80%	—	—	—	—
Inpatient, Percentage	0.73%	—	—	—	—
IOP/PH, Percentage	0.38%	—	—	—	—
Outpatient Mediation Treatment, Percentage	17.33%	—	—	—	—
ED, Percentage	0.09%	—	—	—	—
Telehealth, Percentage	10.35%	—	—	—	—
Plan All-Cause Readmissions (PCR)*					
18–64 Years	7.14%	7.41%	8.58%	4.44%	0.00%

** NCQA national average was not available for comparison.

* For this measure, a lower rate indicates better performance.

HEDIS MY 2022	Humana Health, Contract H4007	Humana Health, Plan ID 016	Humana Health, Plan ID 018	Humana Health, Plan ID 019	Humana Health, Plan ID 022
65+ Years**	11.24%	10.94%	11.11%	9.27%	10.20%
Risk Adjusted Utilization					
Hospitalization Following Discharge from a Skilled Nursing Facility (HFS)**					
30-Day Hospitalization Following D/C, Observed Hospitalization Rate	10.00%	—	—	—	—
60-Day Hospitalization Following D/C, Observed Hospitalization Rate	12.86%	—	—	—	—
Acute Hospital Utilization (AHU)**					
Surgery: Observed Discharge/1,000 Members	26.96	—	—	—	—
Medicine: Observed Discharge/1,000 Members	103.07	—	—	—	—
Total: Observed Discharge/1,000 Members	130.03	—	—	—	—
Emergency Department Utilization (EDU)**					
Observed Discharge/1,000Members	466.08		—	—	—
Hospitalization for Potentially Preventable Complications (HPC)**					
Observed Discharge/1,000Members	28.09	—	—	—	—

** NCQA national average was not available for comparison.

MCS

HEDIS MY 2019 Rates

HEDIS MY HEDIS 2019	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 027	MCS Advantage, Plan ID 028	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 002
Effectiveness of Care: Prevention and Screening					
Colorectal Cancer Screening (COL): Total	93.60%	92.35%	88.04%	87.21%	90.83%
Care for Older Adults (COA)					
Advance Care Planning	97.00%	98.30%	96.84%	98.33%	96.00%
Medication Review	98.00%	99.03%	97.57%	99.17%	98.00%
Functional Status Assessment	96.00%	98.30%	97.08%	99.17%	98.00%
Pain Assessment	98.00%	98.78%	97.81%	99.17%	98.00%
Effectiveness of Care: Respiratory Conditions					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	57.28%	42.11%	50.77%	47.06%	50.00%
Pharmacotherapy Management of COPD Exacerbation (PCE)					
Systemic Corticosteroid	47.18%	44.44%	53.66%	45.65%	39.35%
Bronchodilator	58.47%	52.78%	56.10%	58.70%	49.68%
Effectiveness of Care: Cardiovascular Conditions					
Controlling High Blood Pressure (CBP)	91.00%	86.13%	87.10%	89.05%	82.69%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	81.37%	100.00%	94.12%	100.00%	96.77%

HEDIS MY HEDIS 2019	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 027	MCS Advantage, Plan ID 028	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 002
Effectiveness of Care: Musculoskeletal Conditions					
Osteoporosis Management in Women Who Had a Fracture (OMW)	84.09%	100.00%	66.67%	– —	80.77%
Effectiveness of Care: Behavioral Health					
Antidepressant Medication Management (AMM)					
Effective Acute Phase Treatment	69.72%	70.18%	70.29%	67.44%	61.59%
Effective Continuation Phase Treatment	54.81%	56.14%	59.00%	45.35%	41.20%
Follow-Up After Hospitalization for Mental Illness (FUH)					
Total: 30-Day Follow-Up	79.90%	89.29%	80.30%	72.22%	78.18%
Total: 7-Day Follow-Up	55.95%	46.43%	52.27%	55.56%	50.00%
Effectiveness of Care: Medication Management					
Medication Reconciliation Post-Discharge (MRP)	60.34%	61.11%	58.88%	57.42%	56.20%
Transition of Care (TRC)					
Notification of Inpatient Admission: Total	4.38%	2.78%	3.89%	3.16%	4.87%
Receipt of Discharge Information: Total	2.19%	1.23%	1.22%	1.70%	1.95%
Patient Engagement After	86.86%	87.04%	82.73%	81.51%	79.08%

HEDIS MY HEDIS 2019	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 027	MCS Advantage, Plan ID 028	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 002
Inpatient Discharge					
Medication Reconciliation Post-Discharge	61.56%	60.49%	58.88%	57.91%	56.69%
Effectiveness of Care: Overuse/Appropriateness					
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)					
Falls + Anticonvulsants, Nonbenzodiazepine hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines or Tricyclic Antidepressants	66.53%	74.29%	70.48%	57.14%	57.20%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine hypnotics or Anticholinergic Agents	75.08%	73.33%	72.11%	70.00%	68.95%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-Aspirin NSAIDs	35.45%	36.84%	37.93%	66.67%	23.48%
Total	64.51%	66.67%	65.67%	64.38%	57.21%

HEDIS MY HEDIS 2019	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 027	MCS Advantage, Plan ID 028	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 002
Use of High-Risk Medications in the Elderly (DAE)					
One Prescription	10.56%	15.76%	14.29%	13.11%	8.11%
At Least Two Prescriptions	4.93%	5.42%	5.59%	4.92%	4.17%
Risk Adjusted Utilization					
Plan All-Cause Readmissions (PCR)					
Total Observed Readmission Rate	11.59%	10.00%	15.91%	21.28%	20.22%
Plan All-Cause Readmissions Part-B (PCRB)					
Total Observed Readmission Rate	14.33%	8.22%	9.57%	12.70%	17.86%
Board Certification (BCR)					
Family Medicine	2.23%	2.23%	2.23%	2.23%	2.23%
Internal Medicine	13.62%	13.62%	13.62%	13.62%	13.62%
Pediatricians	10.68%	10.68%	10.68%	10.68%	10.68%
OB/GYN Physicians	24.82%	24.82%	24.82%	24.82%	24.82%
Geriatricians	24.39%	24.39%	24.39%	24.39%	24.39%
Other Physician Specialists	34.28%	34.28%	34.28%	34.28%	34.28%

HEDIS MY 2020 Rates

HEDIS MY 2020	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 028	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 002	MCS Advantage, Plan ID 036
Effectiveness of Care: Prevention and Screening					
Colorectal Cancer Screening (COL): Total*	90.00%	90.12%	86.22%	80.50%	86.67%
Care for Older Adults (COA)*					
Advance Care Planning	97.00%	97.00%	93.00%	97.00%	96.48%
Medication Review	98.00%	99.00%	94.00%	98.00%	97.66%
Functional Status Assessment	98.00%	98.00%	93.00%	97.00%	96.09%
Pain Assessment	99.00%	99.00%	93.00%	98.00%	96.48%
Effectiveness of Care: Respiratory Conditions					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	37.36%	34.88%	59.09%	24.19%	0.00%
Pharmacotherapy Management of COPD Exacerbation (PCE)					
Systemic Corticosteroid	50.64%	49.40%	45.00%	45.71%	23.08%
Bronchodilator	61.31%	57.14%	75.00%	60.95%	38.46%
Effectiveness of Care: Cardiovascular Conditions					
Controlling High Blood Pressure (CBP)	91.84%	89.29%	89.53%	86.00%	78.38%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	88.00%	93.33%	50.00%	100.00%	—

*NCQA national average was not available for comparison.

HEDIS MY 2020	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 028	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 002	MCS Advantage, Plan ID 036
Effectiveness of Care: Musculoskeletal Conditions					
Osteoporosis Management in Women Who Had a Fracture (OMW)*	86.81%	89.47%	100.00%	100.00%	100.00%
Effectiveness of Care: Behavioral Health					
Antidepressant Medication Management (AMM)					
Effective Acute Phase Treatment	62.79%	69.60%	57.24%	56.95%	90.00%
Effective Continuation Phase Treatment	44.74%	52.96%	40.69%	39.84%	60.00%
Follow-Up After Hospitalization for Mental Illness (FUH)					
Total: 30-Day Follow-Up	83.73%	76.34%	88.00%	79.41%	50.00%
Total: 7-Day Follow-Up	54.07%	45.70%	72.00%	54.41%	50.00%
Effectiveness of Care: Medication Management					
Medication Reconciliation Post-Discharge (MRP)*	63.26%	65.21%	60.70%	63.75%	55.17%
Transition of Care (TRC)*					
Notification of Inpatient Admission: Total	3.16%	1.95%	3.93%	1.70%	–
Receipt of Discharge Information: Total	0.49%	0.24%	0.44%	0.00%	–

*NCQA national average was not available for comparison.

HEDIS MY 2020	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 028	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 002	MCS Advantage, Plan ID 036
Patient Engagement After Inpatient Discharge	89.78%	85.89%	87.34%	83.21%	75.86%
Medication Reconciliation Post-Discharge	63.75%	65.45%	61.14%	63.75%	55.17%
Effectiveness of Care: Overuse/Appropriateness					
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)*					
Falls + Anticonvulsants, Nonbenzodiazepine hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines or Tricyclic Antidepressants	57.18%	53.01%	54.55%	50.34%	53.85%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine hypnotics or Anticholinergic Agents	72.38%	66.84%	81.40%	67.11%	89.13%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-Aspirin NSAIDs	33.75%	30.39%	23.53%	24.01%	27.78%
Total	60.48%	54.57%	62.20%	54.53%	76.42%

*NCQA national average was not available for comparison.

HEDIS MY 2020	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 028	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 002	MCS Advantage, Plan ID 036
Use of High-Risk Medications in the Elderly (DAE): Total*	13.59%	13.74%	8.63%	11.41%	12.03%

HEDIS MY 2021 Rates

HEDIS MY 2021	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 037	MCS Advantage, Plan ID 028	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 002	MCS Advantage, Plan ID 036	MCS Advantage Plan ID 038
Effectiveness of Care: Prevention and Screening							
Colorectal Cancer Screening (COL): Total*	85.53%	89.09%	88.05%	85.02%	86.80%	84.54%	85.92%
Care for Older Adults (COL)*							
25%Advance Care Planning	97.00%	99.00%	97.00%	96.67%	99.00%	99.00%	96.00%
Medication Review	96.00%	99.00%	96.00%	97.50%	100.00%	99.00%	96.00%
Functional Status Assessment	97.00%	99.00%	97.00%	96.67%	99.00%	99.00%	96.00%
Pain Assessment	97.00%	99.00%	97.00%	96.67%	99.00%	99.00%	95.00%
Effectiveness of Care: Respiratory Conditions							
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	34.75%	14.29%	26.36%	25.00%	30.69%	30.77%	33.33%

*NCQA national average was not available for comparison.

HEDIS MY 2021	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 037	MCS Advantage, Plan ID 028	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 002	MCS Advantage, Plan ID 036	MCS Advantage Plan ID 038
Pharmacotherapy Management of COPD Exacerbation (PCE)							
Systemic Corticosteroid	46.26%	0.00%	45.95%	26.47%	45.71%	30.36%	–
Bronchodilator	60.34%	100.00%	51.35%	47.06%	71.43%	60.71%	–
Effectiveness of Care: Cardiovascular Conditions							
Controlling High Blood Pressure (CBP)	86.13%	90.51%	83.70%	86.62%	82.73%	85.64%	89.71%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	87.50%	—	95.24%	100.00%	85.19%	66.67%	–
Effectiveness of Care: Musculoskeletal Conditions							
Osteoporosis Management in Women Who Had a Fracture (OMW)*	90.63%	—	88.89%	33.33%	62.50%	100.00%	–
Effectiveness of Care: Behavioral Health							
Antidepressant Medication Management (AMM)							
Effective Acute Phase Treatment	68.46%	75.00%	69.74%	62.50%	68.14%	68.82%	80.00%
Effective Continuation	49.90%	57.14%	53.65%	44.64%	46.45%	55.29%	53.33%

*NCQA national average was not available for comparison.

HEDIS MY 2021	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 037	MCS Advantage, Plan ID 028	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 002	MCS Advantage, Plan ID 036	MCS Advantage Plan ID 038
Phase Treatment							
Follow-Up After Hospitalization for Mental Illness (FUH)							
Total: 30-Day Follow-Up	79.52%	100.00%	86.49%	78.43%	70.55%	79.66%	66.67%
Total: 7-Day Follow-Up	53.46%	75.00%	60.81%	47.06%	48.63%	54.24%	66.67%
Effectiveness of Care: Medication Management							
Transition of Care (TRC)*							
Notification of Inpatient Admission: Total	3.89%	3.57%	3.16%	4.14%	2.19%	2.43%	3.28%
Receipt of Discharge Information: Total	1.22%	1.79%	1.46%	1.22%	1.22%	1.22%	0.00%
Patient Engagement After Inpatient Discharge	89.78%	92.86%	86.37%	87.35%	89.05%	87.35%	83.61%
Medication Reconciliation Post-Discharge	76.40%	83.93%	68.86%	75.18%	74.94%	76.40%	68.85%
Effectiveness of Care: Overuse/Appropriateness							
Potentially Harmful Drug-Disease							

* NCQA national average was not available for comparison.

HEDIS MY 2021	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 037	MCS Advantage, Plan ID 028	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 002	MCS Advantage, Plan ID 036	MCS Advantage Plan ID 038
Interactions in the Elderly (DDE)*							
Falls + Anticonvulsants, Non-benzodiazepine hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines or Tricyclic Antidepressants	55.24%	0.00%	52.50%	50.00%	50.46%	57.75%	57.14%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine hypnotics or Anticholinergic Agents	47.04%	53.33%	45.40%	48.51%	50.05%	63.48%	42.11%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-Aspirin NSAIDs	26.89%	16.67%	24.28%	30.30%	26.68%	28.49%	0.00%

* NCQA national average was not available for comparison.

HEDIS MY 2021	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 037	MCS Advantage, Plan ID 028	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 002	MCS Advantage, Plan ID 036	MCS Advantage Plan ID 038
Total	44.04%	39.13%	41.76%	45.60%	44.92%	51.49%	41.38%
Use of High-Risk Medications in the Elderly (DAE): Total*	24.37%	28.87%	21.66%	20.83%	24.01%	32.84%	19.83%

HEDIS MY 2022 Rates

HEDIS MY 2022	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 037	MCS Advantage, Plan ID 038	MCS Advantage, Plan ID 002	MCS Advantage, Plan ID 036
Effectiveness of Care: Prevention and Screening						
Colorectal Cancer Screening (COL): Total*	88.68%	88.41%	85.96%	91.19%	88.37%	86.96%
Care for Older Adults (COA)*						
Advance Care Planning	98.00%	96.00%	99.00%	96.00%	98.00%	100.00%
Medication Review	98.00%	98.00%	100.00%	97.00%	98.00%	100.00%
Functional Status Assessment	98.00%	96.00%	99.00%	97.00%	97.00%	100.00%
Pain Assessment	98.00%	98.00%	100.00%	97.00%	97.00%	100.00%
Effectiveness of Care: Respiratory Conditions						
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	35.24%	36.07%	12.50%	33.33%	24.78%	35.71%

*NCQA national average was not available for comparison.

HEDIS MY 2022	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 037	MCS Advantage, Plan ID 038	MCS Advantage, Plan ID 002	MCS Advantage, Plan ID 036
Pharmacotherapy Management of COPD Exacerbation (PCE)						
Systemic Corticosteroid	47.80%	40.00%	40.00%	0.00%	44.20%	32.56%
Bronchodilator	63.39%	74.29%	100.00%	50.00%	56.52%	51.16%
Effectiveness of Care: Cardiovascular Conditions						
Controlling High Blood Pressure (CBP)	88.86%	90.34%	88.46%	92.44%	92.08%	91.78%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	85.71%	85.71%	100.00%	100.00%	86.67%	100.00%
Effectiveness of Care: Musculoskeletal Conditions						
Osteoporosis Management in Women Who Had a Fracture (OMW)*	89.04%	100.00%		–	100.00%	100.00%
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	72.73%	67.70%	68.00%	58.33%	71.93%	72.22%
Effective Continuation Phase Treatment	52.55%	52.14%	56.00%	41.67%	53.01%	57.29%
Follow-Up After Hospitalization for						

* NCQA national average was not available for comparison.

HEDIS MY 2022	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 037	MCS Advantage, Plan ID 038	MCS Advantage, Plan ID 002	MCS Advantage, Plan ID 036
Mental Illness (FUH)						
Total: 30-Day Follow-Up	81.42%	77.61%	50.00%	37.50%	76.88%	69.39%
Total: 7-Day Follow-Up	38.35%	47.76%	50.00%	37.50%	41.88%	46.94%
Effectiveness of Care: Medication Management						
Transition of Care (TRC)*						
Notification of Inpatient Admission: Total	4.14%	3.65%	2.96%	5.88%	3.89%	4.62%
Receipt of Discharge Information: Total	0.24%	0.73%	2.22%	0.00%	0.97%	1.22%
Patient Engagement After Inpatient Discharge	91.73%	88.56%	81.48%	84.31%	89.54%	91.00%
Medication Reconciliation Post-Discharge	82.48%	83.21%	83.7%	79.41%	84.43%	84.43%
Effectiveness of Care: Overuse/Appropriateness						
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)*						
Falls + Anticonvulsants, Nonbenzodiazepine hypnotics, SSRIs,	56.37%	42.17%	64.29%	58.33%	51.48%	58.82%

*NCQA national average was not available for comparison.

HEDIS MY 2022	MCS Advantage, Plan ID 017	MCS Advantage, Plan ID 029	MCS Advantage, Plan ID 037	MCS Advantage, Plan ID 038	MCS Advantage, Plan ID 002	MCS Advantage, Plan ID 036
Antiemetics, Antipsychotics, Benzodiazepines or Tricyclic Antidepressants						
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine hypnotics or Anticholinergic Agents	52.79%	55.56%	56.32%	46.67%	51.41%	60.6%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-Aspirin NSAIDs	27.76%	36.36%	23.53%	20.00%	25.05%	24.66%
Total	47.64%	48.32%	52.54%	43.68%	45.56%	51.79%
Use of High-Risk Medications in the Elderly (DAE): Total*	29.23%	24.02%	38.37%	23.67%	28.40%	35.53%

MMM Platino

HEDIS MY 2019 Rates

HEDIS MY 2019	MMM Healthcare, Plan ID 017	MMM Healthcare, Plan ID 048	MMM Healthcare, Plan ID 041	MMM Healthcare, Plan ID 061
Effectiveness of Care: Prevention and Screening				
Colorectal Cancer Screening (COL): Total	91.51%	88.05%	93.19%	90.02%

* NCQA national average was not available for comparison.

HEDIS MY 2019	MMM Healthcare, Plan ID 017	MMM Healthcare, Plan ID 048	MMM Healthcare, Plan ID 041	MMM Healthcare, Plan ID 061
Care for Older Adults (COA)				
Advance Care Planning	97.00%	98.00%	97.81%	96.59%
Medication Review	98.00%	100.00%	98.30%	96.59%
Functional Status Assessment	98.00%	99.00%	98.54%	96.59%
Pain Assessment	98.00%	99.00%	97.81%	96.59%
Effectiveness of Care: Respiratory Conditions				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	24.76%	17.96%	23.68%	33.33%
Pharmacotherapy Management of COPD Exacerbation (PCE)				
Systemic Corticosteroid	44.41%	26.92%	37.35%	47.92%
Denominator	59.99%	43.01%	49.40%	52.08%
Effectiveness of Care: Cardiovascular Conditions				
Controlling High Blood Pressure (CBP)	94.89%	95.62%	94.16%	95.13%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	81.82%	88.89%	91.30%	85.71%
Effectiveness of Care: Musculoskeletal Conditions				
Osteoporosis Management in Women Who Had a Fracture (OMW)	90.78%	82.76%	88.89%	83.33%
Effectiveness of Care: Behavioral Health				
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	58.32%	67.06%	63.57%	61.22%
Effective Continuation Phase Treatment	39.96%	44.94%	45.95%	42.86%
Follow-Up After Hospitalization for Mental Illness (FUH)				
Total: 30-Day Follow-Up	73.79%	54.81%	70.77%	76.62%
Total: 7-Day Follow-Up	50.15%	42.22%	44.62%	44.16%
Effectiveness of Care: Medication Management				

HEDIS MY 2019	MMM Healthcare, Plan ID 017	MMM Healthcare, Plan ID 048	MMM Healthcare, Plan ID 041	MMM Healthcare, Plan ID 061
Medication Reconciliation Post-Discharge (MRP)	60.58%	56.20%	56.45%	61.07%
Transition of Care (TRC)				
Notification of Inpatient Admission: Total	3.65%	0.73%	1.70%	3.41%
Receipt of Discharge Information: Total	0.97%	0.24%	0.24%	0.24%
Patient Engagement After Inpatient Discharge	85.16%	77.62%	79.81%	86.86%
Medication Reconciliation Post-Discharge	60.58%	56.20%	56.45%	61.07%
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)				
Falls + Anticonvulsants, Nonbenzodiazepine Hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines, or Tricyclic Antidepressants	61.55%	65.35%	63.58%	70.18%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine Hypnotics, or Anticholinergic Agents	73.31%	75.37%	72.22%	75.00%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-Aspirin NSAIDs	34.27%	30.99%	34.71%	35.90%
Total	60.74%	64.49%	60.25%	64.77%
Use of High-Risk Medications in the Elderly (DAE)				
One Prescription	29.91%	28.41%	29.68%	32.91%
At Least Two Prescriptions	12.63%	13.43%	11.44%	13.12%

HEDIS MY 2020 Rates

HEDIS MY 2020	MMM Healthcare, Plan ID 017	MMM Healthcare, Plan ID 048	MMM Healthcare, Plan ID 041	MMM Healthcare, Plan ID 061	MMM Healthcare, Plan ID 047
Effectiveness of Care: Prevention and Screening					
Colorectal Cancer Screening (COL): Total*	91.51%	88.05%	93.19%	90.02%	78.67%
Care for Older Adults (COA)*					
Advance Care Planning	96.00%	98.00%	97.81%	96.59%	94.16%
Medication Review	99.00%	100.00%	98.30%	96.59%	95.38%
Functional Status Assessment	97.00%	99.00%	98.54%	96.59%	95.86%
Pain Assessment	99.00%	99.00%	97.81%	96.59%	95.62%
Effectiveness of Care: Respiratory Conditions					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	30.45%	14.91%	25.96%	23.60%	50.00%
Pharmacotherapy Management of COPD Exacerbation (PCE)					
Systemic Corticosteroid	47.50%	35.00%	45.83%	32.70%	27.27%
Denominator	62.12%	47.08%	66.07%	44.49%	81.82%
Effectiveness of Care: Cardiovascular Conditions					
Controlling High Blood Pressure (CBP)	94.89%	95.62%	94.16%	95.13%	85.94%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	92.00%	87.50%	66.67%	69.23%	—
Effectiveness of Care: Musculoskeletal Conditions					

* NCQA national average was not available for comparison.

HEDIS MY 2020	MMM Healthcare, Plan ID 017	MMM Healthcare, Plan ID 048	MMM Healthcare, Plan ID 041	MMM Healthcare, Plan ID 061	MMM Healthcare, Plan ID 047
Osteoporosis Management in Women Who Had a Fracture (OMW)*	71.68%	70.00%	80.00%	50.00%	—
Effectiveness of Care: Behavioral Health					
Antidepressant Medication Management (AMM)					
Effective Acute Phase Treatment	59.90%	66.73%	58.03%	62.60%	66.67%
Effective Continuation Phase Treatment	46.03%	58.46%	45.61%	48.98%	46.67%
Follow-Up After Hospitalization for Mental Illness (FUH)					
Total: 30-Day Follow-Up	69.56%	50.34%	64.35%	65.92%	58.33%
Total: 7-Day Follow-Up	43.39%	38.78%	43.48%	40.45%	33.33%
Effectiveness of Care: Medication Management					
Medication Reconciliation Post-Discharge (MRP)*	72.75%	77.13%	71.78%	67.88%	64.29%
Transition of Care (TRC)*					
Notification of Inpatient Admission: Total	1.46%	1.70%	2.92%	1.46%	
Receipt of Discharge Information: Total	0.00%	0.24%	0.00%	0.00%	2.98%
Patient Engagement After Inpatient Discharge	90.27%	80.54%	87.58%	86.38%	0.00%

* NCQA national average was not available for comparison.

HEDIS MY 2020	MMM Healthcare, Plan ID 017	MMM Healthcare, Plan ID 048	MMM Healthcare, Plan ID 041	MMM Healthcare, Plan ID 061	MMM Healthcare, Plan ID 047
Medication Reconciliation Post-Discharge	74.94%	72.90%	69.58%	66.67%	84.52%
Effectiveness of Care: Overuse/Appropriateness					
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)*					
Falls + Anticonvulsants, Nonbenzodiazepine Hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines, or Tricyclic Antidepressants	47.86%	47.67%	50.81%	36.36%	0.00%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine Hypnotics, or Anticholinergic Agents	69.38%	73.50%	66.39%	59.83%	55.56%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-Aspirin NSAIDs	32.45%	28.02%	34.31%	29.57%	0.00%
Total	54.80%	59.87%	53.81%	46.01%	41.67%
Use of High-Risk Medications in the Elderly (DAE)*	14.60%	16.25%	15.05%	11.27%	12.59%

* NCQA national average was not available for comparison.

HEDIS MY 2021 Rates

HEDIS MY 2021	MMM Healthcare, Plan ID 017	MMM Healthcare, Plan ID 048	MMM Healthcare, Plan ID 049	MMM Healthcare, Plan ID 061	MMM Healthcare, Plan ID 047
Effectiveness of Care: Prevention and Screening					
Colorectal Cancer Screening (COL): Total*	93.88%	90.76%	94.77%	91.82%	89.24%
Care for Older Adults (COA)*					
Advance Care Planning	99%	100%	98.3%	96%	97.17%
Medication Review	99%	100%	99.03%	98%	98.11%
Functional Status Assessment	99%	100%	98.3%	97%	97.17%
Pain Assessment	99%	100%	98.78%	98%	98.11%
Effectiveness of Care: Respiratory Conditions					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	24.77%	15.93%	15%	23.91%	19.15%
Pharmacotherapy Management of COPD Exacerbation (PCE)					
Systemic Corticosteroid	45.37%	37.5%	50%	39.13%	51.85%
Denominator	71.66%	59.62%	50%	65.94%	66.67%
Effectiveness of Care: Cardiovascular Conditions					
Controlling High Blood Pressure (CBP)	88.08%	88.56%	87.31%	88.32%	91.48%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	84.25%	80%	100%	88.1%	81.82%
Effectiveness of Care: Musculoskeletal Conditions					

* NCQA national average was not available for comparison.

HEDIS MY 2021	MMM Healthcare, Plan ID 017	MMM Healthcare, Plan ID 048	MMM Healthcare, Plan ID 049	MMM Healthcare, Plan ID 061	MMM Healthcare, Plan ID 047
Osteoporosis Management in Women Who Had a Fracture (OMW)*	78.64%	90.91%	100%	87.5%	—
Effectiveness of Care: Behavioral Health					
Antidepressant Medication Management (AMM)					
Effective Acute Phase Treatment	61.85%	69.43%	47.73%	69.3%	63.47%
Effective Continuation Phase Treatment	44.65%	57.2%	31.82%	57.41%	48.86%
Follow-Up After Hospitalization for Mental Illness (FUH)					
Total: 30-Day Follow-Up	65.93%	31.25%	37.5%	66.09%	62.5%
Total: 7-Day Follow-Up	42.76%	21.88%	18.75%	38.26%	39.06%
Effectiveness of Care: Medication Management					
Transition of Care (TRC)*					
Notification of Inpatient Admission: Total	87.1%	85.64%	76.03%	79.56%	79.08%
Receipt of Discharge Information: Total	93.19%	90.51%	81.82%	84.43%	85.16%
Patient Engagement After Inpatient Discharge	90.27%	85.4%	80.99%	91.24%	88.08%
Medication Reconciliation Post-Discharge	79.32%	78.35%	66.94%	74.21%	71.53%

* NCQA national average was not available for comparison.

HEDIS MY 2021	MMM Healthcare, Plan ID 017	MMM Healthcare, Plan ID 048	MMM Healthcare, Plan ID 049	MMM Healthcare, Plan ID 061	MMM Healthcare, Plan ID 047
Effectiveness of Care: Overuse/Appropriateness					
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)*					
Falls + Anticonvulsants, Nonbenzodiazepine Hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines, or Tricyclic Antidepressants	49.51%	50%	30.77%	46.63%	48.94%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine Hypnotics, or Anticholinergic Agents	49.05%	58.08%	54.67%	48.25%	50.93%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-Aspirin NSAIDs	32.68%	25.19%	40.91%	34.6%	33.33%
Total	44.71%	50.14%	46.21%	44.54%	46.5%
Use of High-Risk Medications in the Elderly (DAE)*	31.9%	42.83%	36.17%	29.25%	32.13%

* NCQA national average was not available for comparison.

HEDIS MY 2022 Rates

HEDIS MY 2022	MMM Healthcare, Plan ID 017	MMM Healthcare, Plan ID 048	MMM Healthcare, Plan ID 049	MMM Healthcare, Plan ID 061	MMM Healthcare, Plan ID 047
Effectiveness of Care: Prevention and Screening					
Colorectal Cancer Screening (COL): Total*	89.39%	84.28%	90.57%	89.8%	90.7%
Care for Older Adults (COA)*					
Advance Care Planning	99%	99%	99%	100%	99%
Medication Review	100%	99%	99%	100%	99%
Functional Status Assessment	99%	99%	99%	99%	99%
Pain Assessment	99%	100%	99%	100%	99%
Effectiveness of Care: Respiratory Conditions					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	27.69%	19.43%	30%	27.99%	26.61%
Pharmacotherapy Management of COPD Exacerbation (PCE)					
Systemic Corticosteroid	51.2%	45.71%	75%	54.29%	50.55%
Denominator	79.21%	71.43%	83.33%	76.19%	81.32%
Effectiveness of Care: Cardiovascular Conditions					
Controlling High Blood Pressure (CBP)	90.76%	89.67%	98.8%	90.76%	91.84%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	83.02%	100%	100%	76.19%	50%
Effectiveness of Care: Musculoskeletal Conditions					

* NCQA national average was not available for comparison.

HEDIS MY 2022	MMM Healthcare, Plan ID 017	MMM Healthcare, Plan ID 048	MMM Healthcare, Plan ID 049	MMM Healthcare, Plan ID 061	MMM Healthcare, Plan ID 047
Osteoporosis Management in Women Who Had a Fracture (OMW)*	90.68%	100%	100%	88.24%	100%
Effectiveness of Care: Behavioral Health					
Antidepressant Medication Management (AMM)					
Effective Acute Phase Treatment	68.53%	73.61%	68.42%	66.74%	71.86%
Effective Continuation Phase Treatment	54.27%	59.42%	48.42%	53.76%	56.44%
Follow-Up After Hospitalization for Mental Illness (FUH)					
Total: 30-Day Follow-Up	77.8%	47.69%	65.12%	72.14%	71.71%
Total: 7-Day Follow-Up	50.18%	26.15%	32.56%	43.57%	41.46%
Effectiveness of Care: Medication Management					
Transition of Care (TRC)*					
Notification of Inpatient Admission: Total	69.18%	72.92%	64.31%	66.36%	68.42%
Receipt of Discharge Information: Total	72.76%	68.06%	63.17%	62.31%	66.08%
Patient Engagement After Inpatient Discharge	94.62%	91.67%	89.24%	94.39%	93.27%
Medication Reconciliation Post-Discharge	90.32%	90.63%	83.85%	88.16%	86.84%

* NCQA national average was not available for comparison.

HEDIS MY 2022	MMM Healthcare, Plan ID 017	MMM Healthcare, Plan ID 048	MMM Healthcare, Plan ID 049	MMM Healthcare, Plan ID 061	MMM Healthcare, Plan ID 047
Effectiveness of Care: Overuse/Appropriateness					
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)*					
Falls + Anticonvulsants, Nonbenzodiazepine Hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines, or Tricyclic Antidepressants	50.36%	50.2%	27.78%	47.85%	52.15%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine Hypnotics, or Anticholinergic Agents	48.64%	55.74%	42.28%	44.56%	53.17%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-Aspirin NSAIDs	28.97%	19.54%	32.2%	30.51%	32.67%
Total	43.28%	47.61%	38%	41.36%	48.13%
Use of High-Risk Medications in the Elderly (DAE)*	31.78%	40.88%	32.11%	27.87%	30.25%

* NCQA national average was not available for comparison.

Triple S Platino

HEDIS MY 2019 Rates

HEDIS MY 2019	Triple S Advantage, Contract H5774	Triple S Advantage, Plan ID 022	Triple S Advantage, Plan ID 024	Triple S Advantage, Plan ID 025	Triple S Advantage, Plan ID 026
Effectiveness of Care: Prevention and Screening					
Adult BMI Assessment (ABA)	100.00%	—	—	—	—
Breast Cancer Screening (BCS): Total	86.22%	—	—	—	—
Colorectal Cancer Screening (COL): Total	92.93%	84.47%	91.70%	91.40%	87.10%
Care for Older Adults (COA)					
Advance Care Planning	—	99.06%	99.00%	100.00%	94.37%
Medication Review	—	98.11%	99.00%	99.00%	93.33%
Functional Status Assessment	—	99.06%	98.00%	100.00%	95.00%
Pain Assessment	—	96.00%	99.00%	100.00%	95.00%
Effectiveness of Care: Respiratory Conditions					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	28.07%	20.34%	24.59%	31.58%	20.00%
Pharmacotherapy Management of COPD Exacerbation (PCE)					
Systemic Corticosteroid	44.80%	33.33%	45.60%	47.94%	0.00%
Bronchodilator	63.98%	33.33%	68.69%	65.46%	0.00%
Effectiveness of Care: Cardiovascular Conditions					
Controlling High Blood Pressure (CBP)	82.97%	75.45%	74.93%	76.21%	73.02%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	85.33%	75.00%	89.61%	82.61%	0
Statin Therapy for Patients with Cardiovascular Disease (SPC)					
Received Statin Therapy: Total	78.26%	—	—	—	—

HEDIS MY 2019	Triple S Advantage, Contract H5774	Triple S Advantage, Plan ID 022	Triple S Advantage, Plan ID 024	Triple S Advantage, Plan ID 025	Triple S Advantage, Plan ID 026
Statin Adherence 80%: Total	74.95%	—	—	—	—
Effectiveness of Care: Diabetes					
Comprehensive Diabetes Care (CDC)					
Hemoglobin A1c (HbA1c) Testing	96.82%	—	—	—	—
HbA1c Poor Control (>9.0%)	12.71%	—	—	—	—
HbA1c Control (<8.0%)	66.99%	—	—	—	—
Medical Attention for Nephropathy	99.21%	—	—	—	—
Blood Pressure Control (<140/90 mm Hg)	78.73%	—	—	—	—
Eye Exam — Total	88.26%	—	—	—	—
Statin Therapy for Patients with Diabetes (SPD)					
Received Statin Therapy	75.88%	—	—	—	—
Statin Adherence 80%	72.90%	—	—	—	—
Effectiveness of Care: Musculoskeletal Conditions					
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)	82.45%	—	—	—	—
Osteoporosis Management in Women Who Had a Fracture (OMW)	63.84%	80.00%	54.39%	85.71%	—
Effectiveness of Care: Behavioral Health					
Antidepressant Medication Management (AMM)					
Effective Acute Phase Treatment	56.41%	47.37%	62.78%	64.91%	81.25%
Effective Continuation Phase Treatment	38.59%	26.32%	44.78%	45.64%	37.50%

HEDIS MY 2019	Triple S Advantage, Contract H5774	Triple S Advantage, Plan ID 022	Triple S Advantage, Plan ID 024	Triple S Advantage, Plan ID 025	Triple S Advantage, Plan ID 026
Follow-Up After Hospitalization for Mental Illness (FUH)					
Total: 30-Day Follow-Up	70.13%	100.00%	73.68%	60.00%	—
Total: 7-Day Follow-Up	44.16%	100.00%	50.00%	40.00%	—
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					
Total: 30-Day Follow-Up	58.75%	—	—	—	—
Total: 7-Day Follow-Up	30.00%	—	—	—	—
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)					
Total: 30-Day Follow-Up	11.76%	—	—	—	—
Total: 7-Day Follow-Up	2.94%	—	—	—	—
Effectiveness of Care: Medication Management					
Medication Reconciliation Post-Discharge (MRP)	66.91%	39.13%	41.95%	42.93%	45.12%
Transition of Care (TRC)					
Notification of Inpatient Admission: Total	0.00%	0.00%	0.00%	0.00%	0.00%
Receipt of Discharge Information: Total	0.24%	0.00%	0.00%	0.00%	0.00%
Patient Engagement After Inpatient Discharge	80.05%	76.97%	82.24%	80.54%	76.39%
Medication Reconciliation Post-Discharge	66.91%	43.44%	46.96%	46.47%	52.78%
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)					
7-Day Follow-After the ED Visit: Total	44.30%	—	—	—	—

HEDIS MY 2019	Triple S Advantage, Contract H5774	Triple S Advantage, Plan ID 022	Triple S Advantage, Plan ID 024	Triple S Advantage, Plan ID 025	Triple S Advantage, Plan ID 026
Effectiveness of Care: Overuse/Appropriateness					
Non-Recommended PSA-Based Screening in Older Men (PSA)	64.34%	—	—	—	—
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)					
Falls + Anticonvulsants, Nonbenzodiazepine hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines or Tricyclic Antidepressants	56.36%	58.06%	62.51%	63.87%	33.33%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine hypnotics or Anticholinergic Agents	67.18%	61.46%	72.64%	72.24%	56.25%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-aspirin NSAIDs	24.99%	15.49%	26.96%	35.14%	37.50%
Total	56.70%	51.76%	59.90%	61.13%	48.15%
Use of High-Risk Medications in the Elderly (DAE)					
One Prescription	11.43%	6.78%	11.52%	14.85%	10.82%
At Least Two Prescriptions	5.39%	4.25%	6.80%	7.51%	4.33%
Use of Opioids from Multiple Providers (UOP)					
Multiple Prescribers	3.69%	—	—	—	—
Multiple Pharmacies	5.31%	—	—	—	—
Multiple Prescribers and Multiple Pharmacies	0.95%	—	—	—	—
Risk of Continued Opioid Use (COU)					

HEDIS MY 2019	Triple S Advantage, Contract H5774	Triple S Advantage, Plan ID 022	Triple S Advantage, Plan ID 024	Triple S Advantage, Plan ID 025	Triple S Advantage, Plan ID 026
Total — >=15 Days covered	—	—	—	—	—
Total — >=31 Days covered	—	—	—	—	—
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP): Total	98.23%	—	—	—	—
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)					
Initiation of AOD Treatment: Total	6.08%	—	—	—	—
Engagement of AOD Treatment: Total	0.62%	—	—	—	—
Utilization					
Ambulatory Care (AMBA)					
Outpatient Visits/1,000 Enrollee years	10,841.40	—	—	—	—
ED Visits/1,000 Enrollee Years	677.30	—	—	—	—
Inpatient Utilization — General Hospital/Acute Care (IPUA)					
Total Inpatient Discharges/1,000 Enrollee Years	92.89	—	—	—	—
Total Inpatient Days/1,000 Enrollee Years	537.96	—	—	—	—
Total Maternity Discharges/1,000 Enrollee Years	0.24	—	—	—	—
Total Maternity Days/1,000 Enrollee Years	0.61	—	—	—	—
Total Surgery Discharges/1,000 Enrollee Years	6.97	—	—	—	—

HEDIS MY 2019	Triple S Advantage, Contract H5774	Triple S Advantage, Plan ID 022	Triple S Advantage, Plan ID 024	Triple S Advantage, Plan ID 025	Triple S Advantage, Plan ID 026
Total Surgery Days/1,000 Enrollee Years	39.14	—	—	—	—
Total Medicine Discharges/1,000 Enrollee Years	85.84	—	—	—	—
Total Medicine Days/1,000 Enrollee Years	498.45	—	—	—	—
Identification of Alcohol and Other Drug Services (IADA): Total					
Any Services, Percentage	17.44%	—	—	—	—
Inpatient, Percentage	0.22%	—	—	—	—
IOP/PH, Percentage	0.02%	—	—	—	—
Outpatient Mediation Treatment, Percentage	17.19%	—	—	—	—
ED, Percentage	0.21%	—	—	—	—
Telehealth, Percentage	0.01%	—	—	—	—
Mental Health Utilization (MPTA)					
Any Services, Percentage	17.98%	—	—	—	—
Inpatient, Percentage	0.09%	—	—	—	—
IOP/PH, Percentage	0.48%	—	—	—	—
Outpatient Mediation Treatment, Percentage	17.91%	—	—	—	—
ED, Percentage	0.01%	—	—	—	—
Telehealth, Percentage	0.04%	—	—	—	—
Risk Adjusted Utilization					
Plan All-Cause Readmissions (PCR)					
Total Observed Readmission Rate	14.84%	12.50%	13.04%	20.71%	14.29%
Plan All-Cause Readmissions Part-B (PCRB)					

HEDIS MY 2019	Triple S Advantage, Contract H5774	Triple S Advantage, Plan ID 022	Triple S Advantage, Plan ID 024	Triple S Advantage, Plan ID 025	Triple S Advantage, Plan ID 026
Total Observed Readmission Rate	15.00%	21.01%	15.75%	17.72%	12.12%
Hospitalization Following Discharge from a Skilled Nursing Facility (HFS)					
30-Day Hospitalization Following D/C, Observed Hospitalization Rate	0.00%	—	—	—	—
60-Day Hospitalization Following D/C, Observed Hospitalization Rate	0.00%	—	—	—	—
Acute Hospital Utilization (AHU)					
Surgery: Observed Discharge/1,000 Enrollees	9.82	—	—	—	—
Medicine: Observed Discharge/1,000 Enrollees	133.91	—	—	—	—
Total: Observed Discharge/1,000 Enrollees	143.73	—	—	—	—
Emergency Department Utilization (EDU)					
Observed ED Visits/ 1,000 Enrollees	600.62	—	—	—	—
Hospitalization for Potentially Preventable Complications (HPC)					
Observed ACSC Discharges/1,000 Enrollees	33.66	—	—	—	—
Board Certification (BCR)					
Family Medicine	16.00%	16.00%	16.00%	16.00%	16.00%
Internal Medicine	16.30%	16.30%	16.30%	16.30%	16.30%
Pediatricians	0.00%	0.00%	0.00%	0.00%	0.00%
OB/GYN Physicians	38.54%	38.54%	38.54%	38.54%	38.54%
Geriatricians	57.89%	57.89%	57.89%	57.89%	57.89%
Other Physician Specialists	52.46%	52.46%	52.46%	52.46%	52.46%

HEDIS MY 2020 Rates

HEDIS MY 2020	Triple S Advantage, Contract H5774	Triple S Advantage, Plan ID 022	Triple S Advantage, Plan ID 024	Triple S Advantage, Plan ID 025	Triple S Advantage, Plan ID 026	Triple S Advantage, Plan ID 028
Effectiveness of Care: Prevention and Screening						
Adult BMI Assessment (ABA)	100.00%	—	—	—	—	—
Breast Cancer Screening (BCS): Total	87.19%	—	—	—	—	—
Colorectal Cancer Screening (COL): Total*	91.04%	81.14%	91.97%	89.19%	81.29%	91.64%
Care for Older Adults (COA)*						
Advance Care Planning	—	94.00%	98.00%	99.00%	95.00%	99.00%
Medication Review	—	96.00%	99.00%	100.00%	96.00%	100.00%
Functional Status Assessment	—	96.00%	98.00%	99.00%	95.00%	100.00%
Pain Assessment	—	96.00%	98.00%	99.00%	97.00%	99.00%
Effectiveness of Care: Respiratory Conditions						
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	34.33%	18.92%	29.98	33.52%	20.00%	25.45%
Pharmacotherapy Management of COPD Exacerbation (PCE)						
Systemic Corticosteroid	51.04%	12.50%	53.88%	61.68%	0.00%	52.75%
Bronchodilator	70.98%	75.00%	74.69%	77.25%	33.33%	79.12%
Effectiveness of Care: Cardiovascular Conditions						
Controlling High Blood Pressure (CBP)	86.40%	78.03%	81.08%	81.76%	81.17%	78.75%

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HEDIS MY 2020	Triple S Advantage, Contract H5774	Triple S Advantage, Plan ID 022	Triple S Advantage, Plan ID 024	Triple S Advantage, Plan ID 025	Triple S Advantage, Plan ID 026	Triple S Advantage, Plan ID 028
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	85.96%	100.00%	84.62%	81.25%	100.00%	75.00%
Statin Therapy for Patients with Cardiovascular Disease (SPC)						
Received Statin Therapy: Total	83.04%	—	—	—	—	—
Statin Adherence 80%: Total	78.76%	—	—	—	—	—
Effectiveness of Care: Diabetes						
Comprehensive Diabetes Care (CDC)						
Hemoglobin A1c (HbA1c) Testing	97.08%	—	—	—	—	—
HbA1c Poor Control (>9.0%)**	13.87%	—	—	—	—	—
HbA1c Control (<8.0%)	68.86%	—	—	—	—	—
Medical Attention for Nephropathy	98.30%	—	—	—	—	—
Blood Pressure Control (<140/90 mm Hg)	85.40%	—	—	—	—	—
Eye Exam — Total	88.32%	—	—	—	—	—
Statin Therapy for Patients with Diabetes (SPD)						
Received Statin Therapy	79.18%	—	—	—	—	—
Statin Adherence 80%	78.37%	—	—	—	—	—

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Effectiveness of Care: Musculoskeletal Conditions						
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)*	83.59%	—	—	—	—	—
Osteoporosis Management in Women Who Had a Fracture (OMW)*	72.25%	100.00%	77.78%	56.25%	100.00%	100.00%
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	57.14%	53.85%	64.42%	60.34%	80.56%	70.34%
Effective Continuation Phase Treatment	43.51%	40.00%	49.48%	46.68%	61.11%	60.17%
Follow-Up After Hospitalization for Mental Illness (FUH)						
Total: 30-Day Follow-Up	74.97%	66.67%	79.27%	76.27%	50.00%	64.38%
Total: 7-Day Follow-Up	53.86%	66.67%	57.72%	54.24%	37.50%	41.10%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
Total: 30-Day Follow-Up	64.29%	—	—	—	—	—
Total: 7-Day Follow-Up	28.57%	—	—	—	—	—

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HEDIS MY 2020	Triple S Advantage, Contract H5774	Triple S Advantage, Plan ID 022	Triple S Advantage, Plan ID 024	Triple S Advantage, Plan ID 025	Triple S Advantage, Plan ID 026	Triple S Advantage, Plan ID 028
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)						
Total: 30-Day Follow-Up	13.33%	—	—	—	—	—
Total: 7-Day Follow-Up	10.00%	—	—	—	—	—
Effectiveness of Care: Medication Management						
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	75.54%	—	—	—	—	—
Medication Reconciliation Post-Discharge (MRP)*	73.72%	69.83%	74.21%	70.80%	69.30%	71.05%
Transition of Care (TRC)*						
Notification of Inpatient Admission: Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Receipt of Discharge Information: Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Patient Engagement After Inpatient Discharge	78.83%	73.53%	82.73%	85.40%	82.14%	83.70%
Medication Reconciliation Post-Discharge	64.48%	70.59%	69.83%	70.07%	69.64%	71.05%

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Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)*						
7-Day Follow-After the ED Visit: Total	55.61%	—	—	—	—	—
Effectiveness of Care: Overuse/Appropriateness						
Non-Recommended PSA-Based Screening in Older Men (PSA)*	65.46%					
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)*						
Falls + Anticonvulsants, Nonbenzodiazepine hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines or Tricyclic Antidepressants	45.08%	54.76%	52.19%	51.45%	33.33%	35.29%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine hypnotics or Anticholinergic Agents	67.67%	54.12%	73.43%	75.93%	58.82%	69.31%

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Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-aspirin NSAIDs	28.38%	19.61%	27.09%	33.47%	71.43%	32.73%
Total	55.06%	47.53%	57.79%	59.02%	54.55%	52.63%
Use of High-Risk Medications in the Elderly (DAE)*	15.80%	17.35%	18.52%	20.74%	14.95%	18.20%
Use of Opioids at High Dosage (HDO)**	0.47%	—	—	—	—	—
Use of Opioids from Multiple Providers (UOP)**						
Multiple Prescribers	3.88%	—	—	—	—	—
Multiple Pharmacies	20.02%	—	—	—	—	—
Multiple Prescribers and Multiple Pharmacies	2.08%	—	—	—	—	—
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (AAP): Total	98.26%					
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)						
Initiation of AOD Treatment: Total	7.16%	—	—	—	—	—
Engagement of AOD Treatment: Total	0.75%	—	—	—	—	—

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Utilization						
Frequency of Selected Procedures (FSP)**						
Bariatric Weight Loss Surgery Total Procedures/1,000 Enrollee Years	1.90	—	—	—	—	—
CABG Total Procedures/1,000 Enrollee Years*	8.07	—	—	—	—	—
PCI Total Procedures/1,000 Enrollee Years*	47.68	—	—	—	—	—
Cardiac Catheterization Total Procedures/1,000 Enrollee Years*	126.4	—	—	—	—	—
Carotid Endarterectomy Total Procedures/1,000 Enrollee Years*	3.72	—	—	—	—	—
Cholecystectomy, Open Total Procedures/1,000 Enrollee Years	4.41	—	—	—	—	—
Cholecystectomy, Closed Total Procedures/1,000 Enrollee Years	32.30	—	—	—	—	—
Back Surgery Total Procedures/1,000 Enrollee Years	22.35	—	—	—	—	—

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Hysterectomy, Abdominal Total Procedures/1,000 Enrollee Years	9.18	—	—	—	—	—
Hysterectomy, Vaginal Total Procedures/1,000 Enrollee Years	5.92	—	—	—	—	—
Prostatectomy Total Procedures/1,000 Enrollee Years*	26.74	—	—	—	—	—
Total Hip Replacement Total Procedures/1,000 Enrollee Years*	8.10	—	—	—	—	—
Total Knee Replacement Total Procedures/1,000 Enrollee Years*	37.23	—	—	—	—	—
Mastectomy Total Procedures/1,000 Enrollee Years	10.21	—	—	—	—	—
Lumpectomy Total Procedures/1,000 Enrollee Years	15.90	—	—	—	—	—
Identification of Alcohol and Other Drug Services (IADA)*						
Any Services, Percentage	14.29%	—	—	—	—	—
Inpatient, Percentage	0.33%	—	—	—	—	—
IOP/PH, Percentage	0.02%	—	—	—	—	—

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Outpatient Mediation Treatment, Percentage	14.02%	—	—	—	—	—
ED, Percentage	0.16%	—	—	—	—	—
Telehealth, Percentage	0.00%	—	—	—	—	—
Mental Health Utilization (MPTA)*						
Any Services, Percentage	19.29%	—	—	—	—	—
Inpatient, Percentage	0.59%	—	—	—	—	—
IOP/PH, Percentage	0.43%	—	—	—	—	—
Outpatient Mediation Treatment, Percentage	19.19%	—	—	—	—	—
ED, Percentage	0.04%	—	—	—	—	—
Telehealth, Percentage	0.01%	—	—	—	—	—
Risk Adjusted Utilization						
Plan All-Cause Readmissions (PCR)*						
Total Observed Readmission Rate 65+	9.88%	10.46%	10.01%	10.55%	5.41%	13.44%
Hospitalization Following Discharge from a Skilled Nursing Facility (HFS)*						
30-Day Hospitalization Following D/C, Observed Hospitalization Rate	0.00%	—	—	—	—	—

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60-Day Hospitalization Following D/C, Observed Hospitalization Rate	16.67%	—	—	—	—	—
Acute Hospital Utilization (AHU)*						
Surgery: Observed Discharge/1,000 Enrollees	10.89	—	—	—	—	—
Medicine: Observed Discharge/1,000 Enrollees	129.61	—	—	—	—	—
Total: Observed Discharge/1,000 Enrollees	140.50	—	—	—	—	—
Emergency Department Utilization (EDU)*						
Observed Discharge/1,000 Enrollees	577.27	—	—	—	—	—
Hospitalization for Potentially Preventable Complications (HPC)*						
Observed Discharge/1,000 Enrollees	33.78	—	—	—	—	—

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HEDIS MY 2021 Rates

HEDIS MY 2021	Triple S Advantage, Contract H5774	Triple S Advantage, Plan ID 022	Triple S Advantage, Plan ID 024	Triple S Advantage, Plan ID 025	Triple S Advantage, Plan ID 026	Triple S Advantage, Plan ID 028	Triple S Advantage, Plan ID 032
Effectiveness of Care: Prevention and Screening							
Breast Cancer Screening (BCS): Total	83.72 %	—	—	—	—	—	—
Colorectal Cancer Screening (COL): Total*	91.16 %	78.79 %	88.38 %	86.19 %	81.25%	86.00 %	71.43%
Care for Older Adults (COA)*							
Advance Care Planning	—	94.34 %	94.00 %	97.00 %	95.00%	99.00 %	92.54%
Medication Review	—	96.23 %	98.00 %	99.00 %	97.00%	99.00 %	99.25%
Functional Status Assessment	—	95.28 %	98.00 %	97.00 %	96.00%	99.00 %	99.25%
Pain Assessment	—	96.23 %	98.00 %	98.00 %	95.00%	99.00 %	99.25%
Effectiveness of Care: Respiratory Conditions							
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	35.33 %	28.57 %	31.58 %	32.98 %	33.33%	40.21 %	0.00%
Pharmacotherapy Management of COPD Exacerbation (PCE)							
Systemic Corticosteroid	44.68 %	20.00 %	41.91 %	55.00 %	0.00%	43.10 %	0.00%
Bronchodilator	69.79 %	40.00 %	78.68 %	82.50 %	40.00%	70.69 %	33.33%
Effectiveness of Care: Cardiovascular Conditions							
Controlling High Blood Pressure (CBP)	83.70 %	75.17 %	74.57 %	76.47 %	70.44%	75.52 %	83.33%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	86.02 %	75.00 %	89.19 %	87.50 %	100.00 %	84.21 %	0.00%

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Statin Therapy for Patients with Cardiovascular Disease (SPC)							
Received Statin Therapy: Total	85.96 %	—	—	—	—	—	—
Statin Adherence 80%: Total	86.32 %	—	—	—	—	—	—
Effectiveness of Care: Diabetes							
Comprehensive Diabetes Care (CDC)							
Hemoglobin A1c (HbA1c) Testing	95.00 %	—	—	—	—	—	—
HbA1c Poor Control (>9.0%)**	13.89 %	—	—	—	—	—	—
HbA1c Control (<8.0%)	76.94 %	—	—	—	—	—	—
Medical Attention for Nephropathy*	98.87 %	—	—	—	—	—	—
Blood Pressure Control (<140/90 mm Hg)	80.00 %	—	—	—	—	—	—
Eye Exam — Total	90.83 %	—	—	—	—	—	—
Kidney Health Evaluation for Patients with Diabetes (KED) Total*	18.97 %	—	—	—	—	—	—
Statin Therapy for Patients with Diabetes (SPD)							
Received Statin Therapy	81.70 %	—	—	—	—	—	—
Statin Adherence 80%	86.24 %	—	—	—	—	—	—

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Effectiveness of Care: Musculoskeletal Conditions							
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)*	83.73 %	—	—	—	—	—	—
Osteoporosis Management in Women Who Had a Fracture (OMW)*	72.58 %	33.33 %	68.42 %	92.86 %	0.00%	66.67 %	100.00 %
Effectiveness of Care: Behavioral Health							
Antidepressant Medication Management (AMM)							
Effective Acute Phase Treatment	63.77 %	50.00 %	69.95 %	69.14 %	62.50%	69.29 %	57.14%
Effective Continuation Phase Treatment	51.98 %	41.67 %	53.63 %	56.94 %	45.00%	56.85 %	71.43%
Follow-Up After Hospitalization for Mental Illness (FUH)							
Total: 30-Day Follow-Up	57.19 %	40.00 %	53.70 %	68.52 %	43.75%	56.56 %	0.00%
Total: 7-Day Follow-Up	31.91 %	20.00 %	28.40 %	37.04 %	0.00%	36.89 %	0.00%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)							
Total: 30-Day Follow-Up	37.33 %	—	—	—	—	—	—
Total: 7-Day Follow-Up	21.33 %	—	—	—	—	—	—
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)							

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Total: 30-Day Follow-Up	9.52%	—	—	—	—	—	—
Total: 7-Day Follow-Up	4.76%	—	—	—	—	—	—
Effectiveness of Care: Medication Management							
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	78.81 %	—	—	—	—	—	—
Transition of Care (TRC)*							
Notification of Inpatient Admission: Total	1.22%	1.49%	0.49%	0.97%	5.43%	2.19%	1.79%
Receipt of Discharge Information: Total	0.49%	0.75%	0.24%	0.00%	2.17%	0.00%	1.79%
Patient Engagement After Inpatient Discharge	82.73 %	88.06 %	87.10 %	87.35 %	88.04%	87.59 %	78.57%
Medication Reconciliation Post-Discharge	84.91 %	89.55 %	84.91 %	83.45 %	88.04%	84.91 %	87.50%
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)*							
7-Day Follow-After the ED Visit: Total	49.44 %	—	—	—	—	—	—
Effectiveness of Care: Overuse/Appropriateness							
Non-Recommended PSA-Based Screening in Older Men (PSA)*	64.16 %	—	—	—	—	—	—
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)*							

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HEDIS MY 2021	Triple S Advantage, Contract H5774	Triple S Advantage, Plan ID 022	Triple S Advantage, Plan ID 024	Triple S Advantage, Plan ID 025	Triple S Advantage, Plan ID 026	Triple S Advantage, Plan ID 028	Triple S Advantage, Plan ID 032
Falls + Anticonvulsants, Nonbenzodiazepine hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines or Tricyclic Antidepressants	46.95%	48.00%	52.42%	53.76%	56.25%	48.00%	0.00%
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine hypnotics or Anticholinergic Agents	57.38%	48.78%	56.97%	61.83%	60.61%	63.18%	77.97%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-aspirin NSAIDs	30.86%	13.51%	31.46%	29.35%	31.25%	35.63%	42.86%
Total	49.73%	41.62%	49.27%	51.17%	52.31%	51.93%	67.53%
Use of High-Risk Medications in the Elderly (DAE)*	33.21%	30.17%	39.10%	39.34%	30.03%	38.40%	65.38%
Use of Opioids at High Dosage (HDO)**	1.11%	—	—	—	—	—	—
Use of Opioids from Multiple Providers (UOP)**							
Multiple Prescribers	3.26%	—	—	—	—	—	—
Multiple Pharmacies	5.12%	—	—	—	—	—	—
Multiple Prescribers and Multiple Pharmacies	0.63%	—	—	—	—	—	—
Access/Availability of Care							

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HEDIS MY 2021	Triple S Advantage, Contract H5774	Triple S Advantage, Plan ID 022	Triple S Advantage, Plan ID 024	Triple S Advantage, Plan ID 025	Triple S Advantage, Plan ID 026	Triple S Advantage, Plan ID 028	Triple S Advantage, Plan ID 032
Adults' Access to Preventive/Ambulatory Health Services (AAP): Total	98.16 %	—	—	—	—	—	—
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)							
Initiation of AOD Treatment: Total	11.07 %	—	—	—	—	—	—
Engagement of AOD Treatment: Total	0.91%	—	—	—	—	—	—
Utilization							
Frequency of Selected Procedures (FSP)**							
Bariatric Weight Loss Surgery Total Procedures/1,000 Enrollee Years	0.00	—	—	—	—	—	—
CABG Total Procedures/1,000 Enrollee Years*	4.93	—	—	—	—	—	—
PCI Total Procedures/1,000 Enrollee Years*	21.09	—	—	—	—	—	—
Cardiac Catheterization Total Procedures/1,000 Enrollee Years*	42.74	—	—	—	—	—	—
Carotid Endarterectomy Total Procedures/1,000 Enrollee Years*	1.91	—	—	—	—	—	—
Cholecystectomy, Open Total Procedures/1,000 Enrollee Years	2.61	—	—	—	—	—	—

* NCQA national average was not available for comparison.

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Cholecystectomy, Laparoscopic Total Procedures/1,000 Enrollee Years	12.24	—	—	—	—	—	—
Back Surgery Total Procedures/1,000 Enrollee Years	13.62	—	—	—	—	—	—
Hysterectomy, Abdominal Total Procedures/1,000 Enrollee Years	5.93	—	—	—	—	—	—
Hysterectomy, Vaginal Total Procedures/1,000 Enrollee Years	3.49	—	—	—	—	—	—
Prostatectomy Total Procedures/1,000 Enrollee Years*	7.64	—	—	—	—	—	—
Total Hip Replacement Total Procedures/1,000 Enrollee Years*	5.39	—	—	—	—	—	—
Total Knee Replacement Total Procedures/1,000 Enrollee Years*	23.69	—	—	—	—	—	—
Mastectomy Total Procedures/1,000 Enrollee Years	0.61	—	—	—	—	—	—
Lumpectomy Total Procedures/1,000 Enrollee Years	0.43	—	—	—	—	—	—
Identification of Alcohol and Other Drug Services (IADA)*							
Any Services, Percentage	12.41 %	—	—	—	—	—	—
Inpatient, Percentage	0.28%	—	—	—	—	—	—
IOP/PH, Percentage	0.01%	—	—	—	—	—	—

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Outpatient Mediation Treatment, Percentage	11.14 %	—	—	—	—	—	—
ED, Percentage	0.12%	—	—	—	—	—	—
Telehealth, Percentage	3.74%	—	—	—	—	—	—
Risk Adjusted Utilization							
Hospitalization Following Discharge from a Skilled Nursing Facility (HFS) *							
30-Day Hospitalization Following D/C, Observed Hospitalization Rate	0.00%	—	—	—	—	—	—
60-Day Hospitalization Following D/C, Observed Hospitalization Rate	0.00%	—	—	—	—	—	—
Acute Hospital Utilization (AHU)*							
Surgery: Observed Discharge/1,000 Enrollees	8.26	—	—	—	—	—	—
Medicine: Observed Discharge/1,000 Enrollees	96.83	—	—	—	—	—	—
Total Acute: Observed Discharge/1,000 Enrollees	105.09	—	—	—	—	—	—

HEDIS MY 2022 Rates

HEDIS MY 2022	Triple S Advantage, Contract H5774	Triple S Advantage, Plan ID 022	Triple S Advantage, Plan ID 024	Triple S Advantage, Plan ID 025	Triple S Advantage, Plan ID 026	Triple S Advantage, Plan ID 028	Triple S Advantage, Plan ID 032	Triple S Advantage, Plan ID 035
Effectiveness of Care: Prevention and Screening								
Breast Cancer Screening (BCS): Total	87.06%	—	—	—	—	—	—	—

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Colorectal Cancer Screening (COL): Total*	85.64%	85.86%	91.23%	88.57%	83.75%	87.19%	67.86%	87.50%
Care for Older Adults (COA) *								
Advance Care Planning	—	93.87%	96.27%	96.51%	93.22%	94.62%	92.34%	97.52%
Medication Review	—	94.44%	97.35%	97.32%	94.37%	95.89%	93.19%	98.76%
Functional Status Assessment	—	94.60%	97.10%	97.34%	94.12%	95.41%	96.60%	97.52%
Pain Assessment	—	94.69%	97.27%	97.50%	94.25%	95.75%	96.60%	98.14%
Effectiveness of Care: Respiratory Conditions								
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	34.22%	14.29%	29.59%	34.48%	29.03%	33.08%	0.00%	100.00%
Pharmacotherapy Management of COPD Exacerbation (PCE)								
Systemic Corticosteroid	47.88%	33.33%	51.41%	30.30%	40.91%	47.06%	75.00%	66.67%
Bronchodilator	75.85%	50.00%	82.39%	90.91%	77.27%	80.39%	25.00%	66.67%
Effectiveness of Care: Cardiovascular Conditions								
Controlling High Blood Pressure (CBP)	77.59%	77.94%	78.21%	81.90%	82.41%	79.26%	87.50%	79.31%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	89.16%	0.00%	83.33%	71.43%	100.00%	100.00%	0.00%	0.00%
Statin Therapy for Patients with Cardiovascular Disease (SPC)								
Received Statin Therapy: Total	88.52%	—	—	—	—	—	—	—
Statin Adherence 80%: Total	84.90%	—	—	—	—	—	—	—
Effectiveness of Care: Diabetes								

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Comprehensive Diabetes Care (CDC)								
Hemoglobin A1c (HbA1c) Testing	96.56%	—	—	—	—	—	—	—
HbA1c Poor Control (>9.0%)**	27.86%	—	—	—	—	—	—	—
HbA1c Control (<8.0%)	63.89%	—	—	—	—	—	—	—
Medical Attention for Nephropathy*	99.28%	—	—	—	—	—	—	—
Blood Pressure Control (<140/90 mm Hg)	77.00%	—	—	—	—	—	—	—
Eye Exam — Total	85.39%	—	—	—	—	—	—	—
Statin Therapy for Patients with Diabetes (SPD)								
Received Statin Therapy	84.84%	—	—	—	—	—	—	—
Statin Adherence 80%	84.52%	—	—	—	—	—	—	—
Effectiveness of Care: Musculoskeletal Conditions								
Osteoporosis Management in Women Who Had a Fracture (OMW) *	81.52%	100%	90.00%	75.00%	100.00 %	84.62%	—	—
Osteoporosis Screening in Older Women (OSW)*	66.64%	—	—	—	—	—	—	—
Effectiveness of Care: Behavioral Health								
Antidepressant Medication Management (AMM)								
Effective Acute Phase Treatment	70.21%	71.70%	70.67%	71.34%	78.43%	70.91%	83.33%	90.91%
Effective Continuation Phase Treatment	55.79%	54.72%	55.32%	56.72%	60.78%	58.81%	91.67%	63.64%
Follow-Up After Hospitalization for Mental Illness (FUH)								

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Total: 30-Day Follow-Up	66.14%	36.36%	69.63%	73.81%	58.18%	64.36%	0.00%	71.43%
Total: 7-Day Follow-Up	38.71%	36.36%	46.73%	40.48%	27.27%	26.73%	0.00%	71.43%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)								
Total: 30-Day Follow-Up	41.86%	—	—	—	—	—	—	—
Total: 7-Day Follow-Up	17.44%	—	—	—	—	—	—	—
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)								
Total: 30-Day Follow-Up	8.77%	—	—	—	—	—	—	—
Total: 7-Day Follow-Up	5.26%	—	—	—	—	—	—	—
Effectiveness of Care: Medication Management								
Transition of Care (TRC)*								
Notification of Inpatient Admission: Total	—	—	—	—	—	—	—	—
Receipt of Discharge Information: Total	—	—	—	—	—	—	—	—
Patient Engagement After Inpatient Discharge	83.29%	80.75%	84.41%	87.60%	83.00%	85.14%	70.49%	82.57%
Medication Reconciliation Post-Discharge	54.56%	58.49%	59.90%	61.68%	59.68%	53.74%	80.33%	52.29%
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)*								

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7-Day Follow-After the ED Visit: Total	51.17%	—	—	—	—	—	—	—
Effectiveness of Care: Overuse/Appropriateness								
Non-Recommended PSA-Based Screening in Older Men (PSA)*	66.98%	—	—	—	—	—	—	—
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)*								
Falls + Anticonvulsants, Nonbenzodiazepine hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines or Tricyclic Antidepressants	48.57%	42.86%	53.55%	61.88%	44.44%	53.49%	50.00%	100.00 %
Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine hypnotics or Anticholinergic Agents	60.26%	53.13%	62.54%	63.59%	57.26%	59.21%	74.12%	72.73%
Chronic Kidney disease + Cox-2 Selective NSAIDs or Non-aspirin NSAIDs	34.20%	23.53%	35.61%	33.83%	35.56%	34.89%	22.22%	33.33%
Total	52.77%	45.32%	54.07%	55.24%	50.00%	51.64%	68.00%	59.09%
Use of High-Risk Medications in the Elderly (DAE)*	33.61%	33.16%	39.33%	39.85%	32.41%	35.24%	65.45%	50.00%
Use of Opioids at High Dosage (HDO)**	0.43%	—	—	—	—	—	—	—

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Use of Opioids from Multiple Providers (UOP)**								
Multiple Prescribers	3.08%	—	—	—	—	—	—	—
Multiple Pharmacies	5.07%	—	—	—	—	—	—	—
Multiple Prescribers and Multiple Pharmacies	0.63%	—	—	—	—	—	—	—
Access/Availability of Care								
Adults' Access to Preventive/Ambulatory Health Services (AAP): Total	98.46%	—	—	—	—	—	—	—
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)								
Initiation of AOD Treatment: Total	10.13%	—	—	—	—	—	—	—
Engagement of AOD Treatment: Total	0.83%	—	—	—	—	—	—	—
Utilization								
Frequency of Selected Procedures (FSP)**								
Bariatric Weight Loss Surgery Total Procedures/1,000 Enrollee Years	0.00	—	—	—	—	—	—	—
CABG Total Procedures/1,000 Enrollee Years*	5.78	—	—	—	—	—	—	—
PCI Total Procedures/1,000 Enrollee Years*	35.74	—	—	—	—	—	—	—
Cardiac Catheterization Total Procedures/1,000 Enrollee Years*	105.19	—	—	—	—	—	—	—

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Carotid Endarterectomy Total Procedures/1,000 Enrollee Years*	2.75	—	—	—	—	—	—	—
Cholecystectomy, Open Total Procedures/1,000 Enrollee Years	4.77	—	—	—	—	—	—	—
Cholecystectomy, Laparoscopic Total Procedures/1,000 Enrollee Years	10.50	—	—	—	—	—	—	—
Back Surgery Total Procedures/1,000 Enrollee Years	9.66	—	—	—	—	—	—	—
Hysterectomy, Abdominal Total Procedures/1,000 Enrollee Years	3.01	—	—	—	—	—	—	—
Hysterectomy, Vaginal Total Procedures/1,000 Enrollee Years	3.30	—	—	—	—	—	—	—
Prostatectomy Total Procedures/1,000 Enrollee Years*	10.75	—	—	—	—	—	—	—
Total Hip Replacement Total Procedures/1,000 Enrollee Years*	7.56	—	—	—	—	—	—	—
Total Knee Replacement Total Procedures/1,000 Enrollee Years*	26.44	—	—	—	—	—	—	—
Mastectomy Total Procedures/1,000 Enrollee Years	4.59	—	—	—	—	—	—	—
Lumpectomy Total Procedures/1,000 Enrollee Years	1.14	—	—	—	—	—	—	—
Identification of Alcohol and Other Drug Services (IADA)*								

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Any Services, Percentage	12.12%	—	—	—	—	—	—	—
Inpatient, Percentage	0.32%	—	—	—	—	—	—	—
IOP/PH, Percentage	0.02%	—	—	—	—	—	—	—
Outpatient Mediation Treatment, Percentage	11.42%	—	—	—	—	—	—	—
ED, Percentage	0.16%	—	—	—	—	—	—	—
Telehealth, Percentage	1.47%	—	—	—	—	—	—	—
Risk Adjusted Utilization								
Hospitalization Following Discharge from a Skilled Nursing Facility (HFS)*								
30-Day Hospitalization Following D/C, Observed Hospitalization Rate	4.31%	—	—	—	—	—	—	—
60-Day Hospitalization Following D/C, Observed Hospitalization Rate	8.62%	—	—	—	—	—	—	—
Acute Hospital Utilization (AHU)*								
Surgery: Observed Discharge/1,000 Enrollees	9.52	—	—	—	—	—	—	—
Medicine: Observed Discharge/1,000 Enrollees	104.78	—	—	—	—	—	—	—
Total Acute: Observed Discharge/1,000 Enrollees	114.30	—	—	—	—	—	—	—

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Emergency Department Utilization (EDU) Observed Discharge/1,000 Enrollees*	326.47	—	—	—	—	—	—	—
Hospitalization for Potentially Preventable Complications (HPC) Observed Discharge/1,000 Enrollees*	22.07	—	—	—	—	—	—	—

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