Commonwealth of Puerto Rico
Puerto Rico Health Insurance Administration

Annual External Quality Review Technical Report

Contract Years 2012–2013
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1 EXECUTIVE SUMMARY

Purpose of Report

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

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

To meet these federal requirements, the Puerto Rico Health Insurance Administration (PRHIA) has contracted with IPRO, an External Quality Review Organization, to conduct the annual EQR of Puerto Rico's Medicaid managed care plans and the Medicare Advantage Organizations (MAOs) contracted under the Medicare program.

Scope of EQR Activities Conducted

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

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

Validation of Performance Measures (PMs): IPRO conducted Healthcare Effectiveness Data and Information Set HEDIS®[1] compliance audits of the MCO/PIHP processes for calculation and reporting of HEDIS performance measures in 2012 for HEDIS 2011. The HEDIS 2012 and 2013 performance measures are included in this report and are unaudited as IPRO was not contracted with ASES to conduct the audit for these two years. The MCO's submitted their data directly to ASES.

[1] HEDIS-Healthcare Effectiveness Data and Information Set is a registered trademark of the National Committee for Quality Assurance (NCQA)

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

The results of these three EQR activities performed by IPRO are detailed in Section 4, Findings, Strengths, and Recommendations with Conclusions Related to Health Care Quality, Timeliness and Access.

Overall Conclusions and Recommendations

The following is a high-level summary of the conclusions drawn from the findings of the EQR activities regarding the Puerto Rico Medicaid Managed Care health plans strengths and IPRO's recommendations with respect to quality, timeliness and access. Specific findings, strengths, and recommendations are described in detail in Section 4 of this report.

Puerto Rico Medicaid Managed Care Program

The following is a high-level plan-specific summary of the conclusions drawn from the findings of the EQR activities and IPRO's recommendations with respect to quality, timeliness and access.

APS Healthcare – Medicaid

Overall APS performance in the domain of quality was fair.

The MCO reported two PIPs: Obesity and Depression and Depression and Diabetes Well-Being. The Obesity and Depression PIP demonstrated improvement in the metric, PHQ mean. The Depression and Diabetes Well-Being data were pending. Methodological weaknesses were identified for both PIPs in the areas of indicator definitions, measurement periods and sampling strategy. Recommendations were also provided regarding topic selection and relevance and barrier analysis and intervention strategy. Only 8 of 32 elements reviewed for QAPI – Measurement and Improvement, achieved full compliance during this year's compliance monitoring. Seventeen elements scored substantial compliance and 7 scored minimal compliance. There were a variety of deficiencies related to the QI Program Description, QI Work Plan, QI Evaluation and QI Committee functions; development and monitoring consistency with clinical practice guidelines; and health information system, ensuring validity of encounter data, and submission of encounter data.

APS reported the following HEDIS Effectiveness of Care performance measures for the North, Metro North, Northwest, East, Northeast, Southeast, San Juan, Southwest, and West regions:

- Follow-Up after Hospitalization for Mental Illness
- Follow-Up for Children Prescribed ADHD Medications
- Antidepressant Medication Management

In the domain of quality, IPRO recommends that APS:

- Ensure that performance improvement projects are methodologically sound and intervention strategies should be evidence-based and developed after conducting a barrier analysis.
- Examine the regulatory requirements designated not fully met and take corrective action to achieve compliance

- Evaluate the overall performance ranking and three-year trends for all measures, assess region-specific performance and develop and implement targeted intervention strategies to improve performance relative to national benchmarks.

Overall APS performance in the domain of timeliness was fair.
Twenty-one of 48 elements reviewed for the Grievance System were fully compliant. Eighteen elements were substantially compliant, 4 elements were minimally compliant, and 4 elements were non-compliant. Minimal and non-compliance was assessed for elements of policies and procedures for utilization management and appeals and the implementation of requirements for acknowledgment and resolution of grievances and appeals
APS reported the following timeliness-focused HEDIS performance measures for the North, Metro North, Northwest, East, Northeast, Southeast, San Juan, Southwest, and West regions:

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

In the domain of timeliness, IPRO recommends that APS:

- Examine the regulatory requirements designated not fully met, particularly those that earned minimal and non-compliance and take corrective action to achieve compliance.
- Ensure that acknowledgment letters are provided to members for grievances and appeal requests.
- Ensure the Resolution Notices are provided to members and providers for all appeals and grievances and that the content of notices is consistent with requirements.
- Evaluate the gaps that were identified for policies and procedures related to utilization management, grievances and appeals and revised policies and procedures accordingly.

Overall APS performance in the domain of access was mixed.
QAPI – Access was the strongest performing domain for APS. Thirty-eight of 43 elements reviewed for QAPI – Access were fully compliant, 3 were substantially compliant, 1 was minimally complement, and 1 non-compliant. The elements found less than fully compliant were minor omissions in policies and procedures.
APS reported the following access-related HEDIS performance measures for the North, Metro North, Northwest, East, Northeast, Southeast, San Juan, Southwest, and West regions:

- Identification of Alcohol and Other Drug Services
- Mental Health Utilization

Identification of Alcohol and Other Drug Services demonstrated the poorest performance of the access and timeliness measures for behavioral health services, consistently ranking below the mean for all 3 years.
In the domain of access, IPRO recommends that APS:

- Examine the identified policy and procedure gaps and update policies and procedures accordingly.
- Analyze performance for the Identification of Alcohol and Other Drug Services measure, conduct root-cause and barrier analyses, research evidence-based improvement strategies used in similar geographic service areas and implement efforts for improvement to improve access to these important services.

Humana Health Plan (HHP) – Medicaid

Overall HHP performance in the domain of quality was good.
Humana Health Plan reported two PIPs for the Medicaid population: Impact of an initiative for early identification of Chronic Kidney Disease (CKD) in members with Diabetes Mellitus and Controlling High Blood Pressure (CBP). Two of three indicators in the CKD PIP achieved and sustained improvement over the project cycle. For the CBP PIP, 2 of 3 regions demonstrated consistent improvement over from 2011 to 2013.
Twenty-three of the 32 elements reviewed for QAPI – Measurement and Improvement, achieved full compliance during this year's compliance monitoring. Nine elements scored substantial compliance and no elements scored minimal or non-compliance. Areas for improvement relative to reporting Medicaid quality initiatives in the QI Evaluation, PIP interventions, and encounter data were noted.
HEDIS performance measure results demonstrated several areas for improvement. The majority of HHP's rates fell below the NCQA means for each of the HEDIS reporting years in the report. The only rates that were somewhat consistently above the mean were HepA antigen for the Child Immunization measure and Breast Cancer Screening for HEDIS 2012 in the Southeast and Southwest.

In the domain of quality, IPRO recommends that HHP:

- Ensure that Medicaid performance improvement projects are included in the annual QI Evaluation
- Examine the recommendations provided for the PIPs related to barrier analysis and intervention strategies, including development and monitoring of process measures to assess effectiveness of the interventions.
- Continue to monitor and address HEDIS performance measures that fall below the Medicaid mean.

Overall HHP performance in the domain of timeliness was good.
Forty-five of 48 elements reviewed for Grievances were fully compliant. All of the remaining 3 elements achieved substantial compliance. These included elements related to timeliness of UM decisions and contents of notice of action letters for appeals
Overall HHP performance in the domain of timeliness was fair. Most HEDIS measures related to timeliness showed rates below the national Medicaid mean with the exception of the Breast Cancer Screening measure for several of the regions over the three year period.
In the domain of timeliness, IPRO recommends that HHP:

- Evaluate the UM authorization process to determine causes for untimely authorization decisions and take corrective action.
- Ensure that notice of action letters contain all required information, including the action and the reason for the action.
- Consider implementing a quality initiative, perhaps in the form of a PIP, to address screening measures that fall below the HEDIS 10th percentile, such as Well Child Care and Children and Adolescent Access to PCP.

Overall HHP performance in the domain of access was mixed.
HEDIS performance measure results demonstrated several areas for improvement. For example, HHP rates for Prenatal and Postpartum Care, Frequency of Ongoing Prenatal Care, Well Child Visits for the first 15 months (6 or more visits), Well Child Visits for ages 3, 4, and 6 fell below national mean. Breast Cancer Screening and Dental rates were above the NCQA mean for several of the regions during the

three year period. Thirty-five of 44 elements reviewed for QAPI – Access were fully compliant. Five were substantially compliant, 3 minimally compliant and 1 non-compliant. Deficiencies were identified in monitoring access and availability of providers and for the UM program, use of qualified and appropriate health professionals for review of authorization requests and appeals and ensuring that policies reflect that no incentives are provided for UM reviewers to deny services, and ensure that policies and procedures include appropriate actions to be taken when a denial of services is overturned.
In the domain of access, IPRO recommends that HHP:

- Consider implementing quality initiatives, perhaps in the form of a PIP, to address Well Child and Prenatal performance measures.
- Ensure that provider access and availability is monitored and reported regularly.
- Evaluate the gaps identified in the UM program and revise policies and procedures accordingly.

Triple S (SSS) – Medicaid

Overall Triple S performance in the domain of quality was poor.
Triple S reported three PIPs for the Medicaid population: Appropriate Medications for People with Asthma, Cholesterol Screening and Control (of Blood Pressure) in Hypertensive Patients, and Screening for Diabetics – HbA1c Testing and Eye Exams. For all 3 PIPs, the information reported by Triple S was Insufficient to conduct validation and generate external quality review findings. Each of the PIP reports lacked information on the topic relevance and rationale, the indicators, the sampling and data collection methodologies, interventions and data analysis. The data in the results tables could not be interpreted. Measurement timeframes did not appear appropriate and rate calculation seemed incorrect based on the information presented.
Ten of 32 elements reviewed for QAPI – Measurement and Improvement, achieved full compliance during this year's compliance monitoring. Ten elements scored substantial compliance, 10 scored minimal compliance and 1 was judged non-compliant. Deficiencies were related to clinical practice guideline development, the QI Work Plan and QI Evaluation, assessing and improving quality of care and services for ISHCN, and encounter data processing and submission.

HEDIS performance measure results demonstrated several areas for improvement. The majority of Triple S' rates fell below the NCQA means for each of the HEDIS reporting years in the report. The only rates that were somewhat consistently above the mean were HepA antigen for the Child Immunization measure and the Annual Dental Visits.
In the domain of quality, IPRO recommends that Triple S:

- Seek assistance and/or quality improvement training related to PIP development and implementation, particularly for study methodology, data analysis and intervention development and implementation.
- Examine the gaps related to clinical practice guideline development policies and procedures and make necessary revisions.
- Ensure that a QI Work Plan is developed separate from the QI Program Description and ensure ongoing updates, quarterly at a minimum.
- Ensure that the QI Evaluation includes all relevant activities for the Medicaid LOB.
- Establish mechanisms to assess quality of care and service provided to ISHCN.
- Maintain and implement policies and procedures for a health information system capable of collecting, analyzing, integrating, and reporting data.
- Establish and implement policies and procedures for collecting, producing and submitting encounter data.
- Monitor to ensure that data received from providers is accurate and complete and prepare reports of the monitoring efforts.
- Verify the accuracy and timeliness of reported data and complete and prepare reports of verification efforts.
- Screen data for completeness, logic, and consistency complete and prepare reports of the screening efforts.
- Submit encounter data and maintain evidence of submission of data to ASES.
- Continue to monitor and address HEDIS performance measures that fall below the Medicaid mean.

Overall Triple S performance in the domain of timeliness was fair.
Thirty-five of 48 elements reviewed for Grievance achieved full compliance during this year's compliance monitoring. The remaining 13 elements scored substantial compliance. Deficiencies related to communicating policies and procedures for appeals to members, format and content of notice of action and resolution letters, and issuing acknowledgement and resolution letters to members and providers.
Most HEDIS measures related to timeliness showed rates below the national Medicaid mean with the exception of the Breast Cancer Screening measure for several of the regions over the three year period.
In the domain of timeliness, IPRO recommends that Triple S:

- Ensure that information regarding procedures for UM authorizations and appeals is communicated to members.
- Ensure that notice of resolution letters are in easily understood format and language and inform member of their rights to appeal and SFH and to continue benefits and how to request these.
- Ensure that resolution letters contain the results of the resolution and the date
- Ensure that acknowledgment letters are sent and a copy (electronic or paper) is maintained in the file for all grievances and appeals.
- Ensure that resolution letters are sent and a copy (electronic or paper) is maintained in the file for all grievances and appeals
- Consider implementing a quality initiative, perhaps in the form of a PIP, to address screening measures that fall below the HEDIS mean, such as Well Child Care and Children and Adolescent Access to PCP.

Overall Triple S performance in the domain of access was fair.
HEDIS performance measure results demonstrated several areas for improvement. For example, Triple S rates for Prenatal and Postpartum Care, Frequency of Ongoing Prenatal Care, Well Child Visits for the first 15 months (6 or more visits), Well Child Visits for ages 3, 4, and 6 fell below national mean. Breast Cancer Screening and Dental rates were above the NCQA mean for several of the regions during the three year period.
All elements reviewed for QAPI – Access were fully compliant.
In the domain of access, IPRO recommends that Triple S:

- Consider implementing quality initiatives, perhaps in the form of a PIP, to address Well Child and Prenatal performance measures.

2. BACKGROUND

Puerto Rico Medicaid Managed Care Program

Puerto Rico's Medicaid Office, representing the Department of Health of Puerto Rico and the Puerto Rico Health Insurance Administration (PRHIA), contracted IPRO to conduct the EQR of the health plans participating in the Medicaid Program for Policy Year 2012-2013 as set for in 42 CFR §438.356(a)(1). After completing the EQR process, IPRO prepared this *2009-20109 External Quality Review Technical Report for Puerto Rico Medicaid Managed Care,* in accordance with 42 CFR §438.364, that describes the manner in which data from activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and how conclusions were drawn as to the *quality, timeliness*, and *access* to the care furnished to Puerto Rico's Medicaid recipients by their MCOs/PIHPs.

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

- Monitoring of the compliance with standards
- Validation of PMs
- Validation of PIPs
- Review of Medicare information: QIPs, HEDIS

This report presents the findings for all the health plans participating in the Puerto Rico's Medicaid Managed Care Program during Policy Year 2012-2013:

For the Medicaid recipients under the *Mi Salud* coverage:

- MCOs for physical health coverage: APS, Humana, and Triple S.
- Mental Behavioral Health Organizations (MBHOs) for mental health coverage: APS Healthcare.

For the dual-eligible recipients under the *Medicare* coverage, the Medicare Advantage Organizations (MAOs): American Health Medicare, First Plus, Humana, Medical Card System, MMM, PMC and Triple S.

Puerto Rico Health Insurance Administration Quality Goals and Objectives

The PRHIA presented the *Medicaid Quality Strategy for Puerto Rico* to CMS on March 1, 2007 and established the following objectives for the Puerto Rico's Medicaid Office and its contracted health plans:

1. To evaluate and strengthen the access and quality of health care delivered through the MCO/PIHPs by adopting and implementing three mandatory EQR activities:

    a. Performance Improvement Projects (42 CFR §438.358(b)(1))
    b. Performance Measures (42 CFR §438.358(b)(2))
    c. Plan Compliance Evaluation Program (42 CFR §438.358(b)(3))

2. To increase the access of the Medicaid population in the utilization of preventive and screening services, as established in the contractual agreement between Medicaid, its agent and the MCO/PIHPs. The expected increment in preventive and screening services should be on a 10% target based on the following clinical aspects:

a. Cancer screenings for breast, cervical, prostate and colon cancers
b. Glaucoma screenings for the elderly population
c. Child immunizations
d. Access to prenatal care in the first trimester
e. Annual dental visits
f. Compliance with EPSDT guidelines
g. HbA1c level control for Medicaid enrollees with Diabetes Mellitus
h. Initiation and engagement of alcohol and other drug dependence treatment
i. Identification of alcohol and other drug services

3. To establish an Integrated Regional Service Model as a demonstrative project in the Metro-north region that guarantees the Medicaid enrollees access to healthcare services for physical and mental health integration and coverage, through a preferential provider network that will include Academic Medical Centers, State and Municipal health facilities.

4. To develop and implement a Disease Management Program for the mental health coverage focusing on the continuity of health care through prevention, clinical and educational components which includes the utilization control and the cost of those chronically ill with conditions that may include, but not limited to, depression, schizophrenia, psychosis. This program intends to improve:

    a. Quality of mental health services
    b. Better access to mental health services
    c. Decrease the incidence of those mental health chronically ill conditions monitored in the disease Management Program
    d. Coordinate the physical and mental health integrated approach

5. To increase the use of the Triage and Customer Service Calling Center by a 10% target based on guaranteeing access, timeliness and quality of healthcare of the Medicaid enrollees on an annual basis.

6. To assess the adoption of a Pay for Performance Program (P4P), as an actuarial and financial arrangement initiative at the primary care level to ensure the quality of healthcare services furnished to the Medicaid population for cost benefit and effectiveness purposes.

An updated Quality Strategy was developed by Puerto Rico in the Fall of 2013 and will be used for the next Technical Report.

3. EXTERNAL QUALITY REVIEW ACTIVITIES

During the past year, IPRO conducted a compliance monitoring site visit, validation of performance measures and validation of performance improvement projects for Puerto Rico Medicaid and Medicare dual eligible managed care plans. Each activity was conducted in accordance with CMS protocols for determining compliance with Medicaid managed care regulations. Details of how these activities were conducted are described in Appendices A-C, and address:

- Objectives for conducting the activity;
- Technical methods of data collection;
- Descriptions of data obtained; and
- Data aggregation and analysis.

Conclusions drawn from the data and recommendations related to access, timeliness and quality are presented in Section 1, Executive Summary, of this report.

4. FINDINGS, STRENGTHS, AND RECOMMENDATIONS WITH CONCLUSIONS RELATED TO HEALTH CARE QUALITY, TIMELINESS AND ACCESS

Introduction

This section of the report addresses the findings from the assessment of the Medicaid MCO's strengths and areas for improvement related to quality, timeliness and access. The findings are detailed in each subpart of this section (i.e., Compliance Monitoring, Validation of Performance Measures and Validation of Performance Improvement Projects).

Compliance Monitoring

Review of Medicaid Managed Care Organization Compliance with Regulatory Requirements

This section of the report presents the results of the reviews by IPRO of Puerto Rico MCO/PIHPs' compliance with regulatory standards and contract requirements for contract year 2012-2013. The information is derived from IPRO's conduct of the annual compliance reviews in December 2013/January 2014.

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

Requirements contained within CFR 42 Subparts C: Enrollee Rights, D: Quality Assessment and Performance Improvement, and F: Grievance System was reviewed.

A description of the content evaluated under each domain follows:

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

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

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

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

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

File reviews were conducted for the following:

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

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

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

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

APS Healthcare 2013 Medicaid Compliance Review Findings for Contract Year 2012-2013

A summary of the Medicaid compliance results for APS Healthcare is provided below. For each standard, the following is provided: current year overall category compliance designations; a description of the current year findings for all standards/elements not found fully compliant including a summary of the file review results. These are preliminary results, as APS had just submitted its responses when this report was written. Assessment of the effectiveness of the plan's progress for elements not fully compliant in the prior review follows the 2013 findings.

APS Healthcare: Summary of 2013 Medicaid Managed Care Compliance Review Findings (Review Year 2012/2013)						
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**	**Number of Elements Not Applicable**
Grievance System	48	21	18	4	4	1
Enrollee Rights and Protections	50	42	1	0	1	6
Quality Assessment and Performance Improvement (QAPI) – Access	47	38	3	1	1	4
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	13	6	0	0	0	7
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	32	8	17	7	0	0

APS Healthcare: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
Grievance System	▪ P/Ps do not indicate that a provider may request an Administrative Law Hearing (ALH) on behalf on an enrollee. The process for requesting an ALH is not described in detail in the Member Handbook – Substantial ▪ P/Ps do not indicate that notices of action include the right to request a fair hearing; template letters do not include a reference to ALH. However, 20 of 20 UM files reviewed included a notice of action with the right to request SFH - Substantial ▪ P/Ps indicate that notices of action include appeal rights, but the process for requesting an appeal is not described. The letter template includes information on how to file an appeal. In the file review, 20 of 20 files included information on how to file an appeal – Substantial. ▪ P/Ps include information on extensions for appeals, but do not address extensions for other UM decisions. There were no files with a request for extension – Substantial. ▪ P/Ps do not address provisions for UM decisions that are not reached within required time frame – Non-Compliance. ▪ P/Ps do not address providing enrollees with assistance in completing forms and procedural steps. The Member Handbook states that MCO staff may assist enrollees with filing a complaint. The template denial letters include contact information if assistance is needed – Substantial. ▪ P/P does not address acknowledgement of receipt of appeals and the letter template provided is the same as for grievances. File Review: No appeals files included acknowledgement letters though most were resolved the same day or within 72 hour – Minimal. ▪ P/P does not include which department/staff are responsible

APS Healthcare: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	for reviewing complaints/grievances - Substantial. ▪ P/P includes the enrollee's right to present evidence in support of the appeal. The adverse determination letter templates included information on documentation needed for an appeal and the timeframes for determination and the sample adverse determination letters also included this information. File review – none of the expedited appeals files contained documentation that the enrollee was informed of the limited time to present evidence – Substantial. ▪ P/P addresses the enrollee's right to examine the case file during the appeal process, however, sample appeal resolution letters and the Member Handbook address the right to request the case file after the appeal is resolved. File Review – the files reviewed did not contain any evidence that an acknowledgement letter was sent - Minimal. ▪ P/P do not address that the estate of a deceased enrollee may be a party to the appeal. File Review – this was not applicable – Substantial. ▪ P/P indicates that written notice for disposition of grievances will be mailed within 90 days of receipt, however, P/P also state that if verbal notification is provided within 5 days of receipt, written notice will not be sent. For complaints, P/P state that resolution letters will be sent within 72 hours. File Review - 4 of 20 files did not contain written notices of resolution, though the documentation stated that written resolution would be sent to the enrollee. In 3 of 4 cases, the resolution had been communicated verbally. All were resolved on the same day or within 5 days – Substantial. ▪ P/P provides a timeframe for written resolution of appeals within 30 calendar days/with extension if needed and within 7 calendars days for pharmacy. File review – all appeals were

APS Healthcare: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	resolved within 30 days with no extensions; however, 6 of 11 files did not contain written resolution though the file indicated written notice would be sent. - Minimal. ▪ P/P indicates that expedited appeals will be resolved and the party given written notice of the resolution within 72 hours. File Review: All expedited appeals were resolved timely but 3 of 9 did not contain written resolution letter, though the file indicated written notice would be sent - Minimal. ▪ P/P indicates that written notice of appeal disposition will be sent for all appeals and oral notice will be provided for expedited appeals. Template letters were provided. File Review: 6 of 11 standard appeals and 3 of 9 expedited appeals files did not contain written notices, though the file indicated written notice would be sent - Minimal. ▪ P/P states that written notice for appeal resolution will include the results but does not address including the date completed. Template letters contain the results; date of notice; and date appeal was received only – Substantial. ▪ P/P states that written appeal resolution letters should contain information on the next level of appeal though request for an ALH is not addressed. The letter template contains the right to ALH and how to request it. File Review – the resolution letters were not the same as the template. The letters included the right to ALH but not how to request this - Substantial. ▪ P/P addresses the member's right to request continuation of benefits during any type of appeal. The right to continuation of benefits during a hearing is not stated in the P/P but is included in template resolution notices. File Review: All upheld appeal notices included the right to continuation of benefits – Substantial. ▪ Appeal resolution template letter addresses the member's

APS Healthcare: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	potential financial liability for the cost of benefits if the ALH upholds the denial. This is not addressed in the letter contained in the P/P. File Review: All files for upheld appeals contained this information - Substantial. ▪ The Provider Manual indicates that punitive action will not be taken against a provider who requests an expedited appeal or supports an enrollee's request. This does not appear in the P/P – Substantial. ▪ Information about the grievance system is addressed for providers and subcontractors in the P/P, Provider Manual, and sample contracts. The availability of enrollee assistance in filing is not addressed – Substantial. ▪ The P/P describes the tracking system for grievances and appeals though the specific information recorded is not addressed – Substantial. ▪ Duration of continuation of benefits while the MCO appeal or Fair Hearing is pending is not addressed in the P/P – Substantial. ▪ P/P does not address the requirement to provide or authorize services not provided while the appeal is pending if the decision is overturned – Non-Compliance. ▪ P/P does not address the requirement to pay for services provided while the appeal is pending if the decision is overturned – Non-Compliance. <u>Summary of Grievance File Review Findings (Total Files Reviewed: 20)</u> In many cases, it was not clear whether a case was classified as a complaint or a grievance and there are different policies and procedures for each of these, especially with regard to the requirement for a written resolution notice. An issue that is resolved within 5 days is a complaint not a grievance.

APS Healthcare: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	▪ 20 of 20 contained documentation of acknowledgement of receipt letters ▪ 1 of 20 involved a clinical concern and was referred for review appropriately ▪ 20 of 20 were resolved timely, within 90 days or less ▪ 0 of 20 had request for extension ▪ 4 of 20 files did not contain a written resolution notice to the member, though there was notation in the file that a letter would be mailed. All 4 were resolved the same day or within 5 days. 3 had a notation of verbal communication of resolution. <u>Summary of Appeals File Review Findings (Total Files Reviewed: 20)</u> 11 standard appeals and 9 expedited appeals were reviewed ▪ All files contained a written request if initially requested orally ▪ No files involved a deceased enrollee/estate as party to the appeal ▪ 0 of 20 files contained an acknowledgement letter ▪ No requests for expedited appeal were denied ▪ 0 of 9 expedited appeal files contained notification to the enrollee of limited time to present evidence ▪ 20 of 20 appeals were reviewed by appropriate personnel ▪ 0 of 20 appeal files involved a request for extension ▪ 11 of 11 standard appeals were resolved within 30 days (most resolved the same day or within 72 hours) ▪ All appeals were resolved within 90 days of receipt of the oral request ▪ 9 of 9 expedited appeals were resolved timely, within 72 hours ▪ 6 of 11 standard appeal files did not contain written resolution notices, though the file indicated written notice would be sent and a resolution letter was sent to the provider ▪ 3 of 9 expedited appeals files did not contain written notices,

APS Healthcare: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	though the file indicated written notice would be sent. ▪ 11 of 11 appeal files with resolution notices contained results and date in the notice ▪ Expedited appeals had documentation of attempts to provide oral notice to providers ▪ All upheld appeal notices included the right to SFH but not how to request one, although a phone # for information was provided. Note that the resolution letters in the files were not the same as the template. ▪ All upheld appeal notices included the right to continuation of benefits ▪ All upheld appeal notices included the enrollee's potential financial responsibility for continued benefits if the SFH upholds the denial. <u>Summary of Utilization Management File Review Findings (Total Files Reviewed: 20)</u>: ▪ 0 of 20 files involved a request for extension ▪ 20 of 20 UM cases were resolved within required timeframes ▪ 20 of 20 UM files contained a timely notice of action ▪ 20 of 20 notices of action were provided in an easily understood manner and format ▪ 20 of 20 notices contained the reason(s) for the action ▪ 20 of 20 UM files contained the right to appeal and how to file an appeal ▪ 20 of 20 notices contained the circumstances under which expedited resolution can be requested and how to request this
Enrollee Rights and Protections	▪ P/Ps do not address that the MCO makes a good faith effort to give written notice to affected enrollees of termination of a contracted provider within 15 days of receipt/issuance of termination notice – Non-Compliance.

APS Healthcare: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	▪ Provider Directory does not address providers who are not accepting new patients - Substantial.
Quality Assessment and Performance Improvement (QAPI) – Access	▪ P/Ps do not address monitoring the number of providers who are not accepting new patients. No documentation to demonstrate this – Non-Compliance. ▪ P/P do not address sharing information on ISHCN with other MCOs to prevent duplication of services – Minimal. ▪ P/P do not address extensions for UM decisions – Substantial <u>Summary of Care Management File Review Findings (Total Files Reviewed: 20)</u>: ▪ Ten case management files were reviewed. All files achieved 100% compliance with requirements.
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ All applicable requirements were Fully Compliant. <u>Summary of Credentialing & Re-credentialing Review Findings (Total Files Reviewed: 13)</u>: ▪ 13 credentialing/re-credentialing files were reviewed. All files achieved 100% compliance with requirements.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ Evidence was not provided for review of CPGs by the APS-PR QI Committee or local provider network – Substantial ▪ Evidence of review and update of CPGs was not provided – Minimal ▪ Evidence of monitoring for consistency of application of CPGs was not provided –Substantial ▪ There is no Provider Advisory Committee/avenue for network provider input – Substantial ▪ The QI Work Plan lacked all relevant activities; planning and implementation of interventions and reassessment; progress from year to year - Substantial ▪ The QI Work Plan and QI Evaluation were not consistent with regard to activities reported - Substantial

APS Healthcare: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	▪ The QI Committee minutes were not complete, participants could not be identified, and there was a lack of evidence of the committee fulfilling its functions - Substantial ▪ Barriers to performance were not identified and system interventions were not evident - Substantial ▪ Progression of PIPs is not evident in the QI Work Plan, QI Evaluation, or QI Committee meeting minutes. ▪ PIP reports lack specific interventions, identification of barriers and indicator numerator and denominator specifications, and a timeline was not provided - Substantial. ▪ Some PIPs did not contain measurement results and there was no evidence of evaluation of the effectiveness of interventions in the QI Committee meeting minutes or QI Evaluation - Substantial. ▪ All performance measures were not included in the QI Program Description and the QI Evaluation - Substantial ▪ The QI Evaluation lacked a discussion of the results, analysis, and proposed next steps for the PIPs – Substantial ▪ There is no P/P to address collection, production and submission of encounter data - Minimal ▪ Corrective actions for high and moderate risk areas identified in an audit were not completed – Minimal ▪ There is no P/P to address or documentation to support verifying the accuracy and completeness of provider and vendor submitted data – Minimal ▪ There is no P/P for or documentation of submission of encounter data to ASES – Minimal

APS Healthcare: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant	**Follow-Up Findings: Current Status**
Standard: Grievance System	
▪ Acknowledgement of receipt for member grievances, member appeals, and provider appeals Substantial Compliance: One file for review could not be located; therefore, it could not be reviewed.	▪ 2013 Review Determination: Minimal Appeals files did not contain documentation of acknowledgement letters.
▪ Enrollee Right to request a Fair Hearing Substantial Compliance: Not addressed in the letters of files reviewed for appeals.	▪ 2013 Review Determination: Substantial All files reviewed included the right to request SFH, though this was not found in the P/P or letter template. Substantial.
▪ Procedures for enrollee to request a Fair Hearing Substantial Compliance: Not addressed in the letters of files reviewed for appeals.	▪ 2013 Review Determination: Substantial. No files reviewed included how to request an ALH. P/P do not address requesting an ALH though the letter template contains the right to ALH and how to request it.
▪ The enrollee's right to have benefits continue pending resolution of appeal, how to request this, and circumstances in which the enrollee will be required to pay the costs of services Substantial Compliance: Not addressed in the letters of files reviewed for appeals.	▪ 2013 Review Determination: Substantial The right to continuation of benefits during all types of appeals is addressed in the P/P. The right to continuation of benefits during a hearing is not stated in the P/P, but is included in resolution notices template. The resolution letter template addresses potential financial liability if the ALH upholds the denial but this is not included in the letter contained in the P/P. All files reviewed for upheld appeals contained the right to continuation of benefits and the potential financial liability.
▪ Duration of continuation of benefits while the MCO appeal or Fair Hearing are pending Substantial Compliance: Unable to verify in Member Handbook and P/P provided.	▪ 2013 Review Determination: Non-Compliance Duration of continuation of benefits is not addressed in the P/P.
▪ MCO mails advance notice of adverse determination at least 10 days prior to date of action	▪ 2013 Review Determination: Not Applicable

APS Healthcare: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant	**Follow-Up Findings: Current Status**
Non Compliance: No documentation provided to address this.	Review element noted as "For Reference Only" in the tool.
▪ Exceptions to mailing advance notice of action at least 10 days prior Non-Compliance: No documentation provided to address this.	▪ 2013 Review Determination: Not Applicable Review element noted as "For Reference Only" in the tool.
▪ The period of advance notice may be shortened to 5 days if the MCO has verified cause to suspect probable fraud Non-Compliance: No documentation provided to address this.	▪ 2013 Review Determination: Not Applicable Review element noted as "For Reference Only" in the tool.
<u>Summary of Grievance File Review Findings (Total Files Reviewed: 5)</u>: ▪ Five member grievance files were reviewed. All files achieved 100% compliance with requirements.	<u>Summary of Grievance File Review Findings (Total Files Reviewed: 20)</u> ▪ 4 of 20 files did not contain a written resolution notice to the member, though there was notation in the file that a letter would be mailed. All 4 were resolved the same day or within 5 days. 3 had a notation of verbal communication of resolution.
<u>Summary of Appeals File Review Findings (Total Files Reviewed: 24)</u>: ▪ Twelve member appeal files were reviewed. None of the files included the enrollee's right to have benefits continue pending resolution of the appeal, and the circumstances under which the enrollee may have to pay the costs of services. ▪ Twelve provider appeal files were reviewed. One requested file could not be located and was not provided. Of the 11 files reviewed, all files were compliant with most requirements. None of the files included the enrollee's right to have benefits continue pending resolution of the appeal, and the circumstances under which the enrollee may have to pay the costs of services.	<u>Summary of Appeals File Review Findings (Total Files Reviewed: 20)</u> ▪ 0 of 20 files contained an acknowledgement letter ▪ 0 of 9 expedited appeal files contained notification to the enrollee of limited time to present evidence ▪ 6 of 11 standard appeal files did not contain written resolution notices, though the file indicated written notice would be sent and a resolution letter was sent to the provider ▪ 3 of 9 expedited appeals files did not contain written notices, though the file indicated written notice would be sent.
<u>Summary of Utilization Management File Review Findings (Total Files Reviewed: 20)</u> All files achieved 100% compliance with requirements.	<u>Summary of Utilization Management File Review Findings (Total Files Reviewed: 20)</u>: ▪ 0 of 20 files involved a request for extension ▪ 20 of 20 UM cases were resolved within required timeframes ▪ 20 of 20 UM files contained a timely notice of action ▪ 20 of 20 notices of action were provided in an easily understood manner and format ▪ 20 of 20 notices contained the reason(s) for the action

APS Healthcare: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant	**Follow-Up Findings: Current Status**
	▪ 20 of 20 UM files contained the right to appeal and how to file an appeal ▪ 20 of 20 notices contained the circumstances under which expedited resolution can be requested and how to request this
Enrollee Rights and Protections	
▪ MCO provides required information to potential enrollees at required time frames Non-Compliance: Marketing materials not submitted for review. Marketing is managed at MCO headquarters.	▪ 2013 Review Determination: Full Compliance
▪ MCO provides required information to potential enrollees Substantial Compliance: Provider Directory does not address providers who are not accepting new patients.	▪ 2013 Review Determination: Substantial Provider Directory does not address providers who are not accepting new patients.
▪ MCO provides information to enrollees regarding coverage for emergency services Non-Compliance: Member Handbook does not address information regarding emergency post-stabilization care.	▪ 2013 Review Determination: Full Compliance
▪ MCO notifies enrollees of additional information that is available on request, e.g., structure and operation of the MCO Non-Compliance: Notification to enrollees not found in documents or P/P provided.	▪ 2013 Review Determination: Full Compliance
▪ MCO provides enrollees with information on provider incentives Non-Compliance: Not addressed in documentation provided.	▪ 2013 Review Determination: Full Compliance
▪ Written policies and procedures for Advance Directives, including all requirements Substantial Compliance: revision to comply with changes in State law as soon as possible, but not greater than 90 days.	▪ 2013 Review Determination: Full Compliance
▪ Written policies and procedures for Advance Directives, including all requirements Substantial Compliance: No evidence of MCO staff education Advance Directives in P/P or staff orientation documents provided for review. No evidence in P/P	▪ 2013 Review Determination: Full Compliance

APS Healthcare: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant	**Follow-Up Findings: Current Status**
related to provision of information that complaints concerning non-compliance may be filed with the State survey and certification agency.	
Quality Assessment and Performance Improvement (QAPI) – Access	
▪ All requirements Fully Compliant.	▪ 2013 Review Determination: Varied
Summary of Care Management File Review Findings (Total Files Reviewed: 10): ▪ Ten case management files were reviewed. All files achieved 100% compliance with requirements.	▪ 2013 Review Determination: Full Compliance
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	
▪ All requirements Fully Compliant.	▪ 2013 Review Determination: All applicable review elements were Fully Compliant
Summary of Credentialing & Re-credentialing Review Findings (Total Files Reviewed: 12): ▪ Six credentialing files were reviewed. All files achieved 100% compliance with requirements. ▪ Six re-credentialing files were reviewed. All files achieved 100% compliance with requirements.	▪ 2013 Review Determination: Full Compliance
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	
▪ Performance Improvement Projects include an evaluation of the effectiveness of the interventions Substantial Compliance: The Ambulatory Follow-Up after Hospitalization for Mental Illness did not achieve improvement at the time of re-measurement.	▪ 2013 Review Determination: Substantial There was no measurement results provided for some of the PIPs, progression of the PIPs was not found in the QI Committee meeting minutes or QI Evaluation.

Humana Health Plan (HHP) 2013 Medicaid Compliance Review Findings for Contract Year 2012-2013

A summary of the Medicaid compliance results for Humana Health Plan is provided below. For each standard, the following is provided: current year overall category compliance designations; a description of the current year findings for all standards/elements not found fully compliant including a summary of the file review results, and HHP's response and action plan as applicable. Assessment of the effectiveness of the plan's progress for elements not fully compliant in the prior review follows the 2013 findings.

Humana Health Plan: Summary of 2013 Medicaid Managed Care Compliance Review Findings (Review Year 2012/2013)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	48	45	3	0	0
Enrollee Rights and Protections	48	39	5	2	2
Quality Assessment and Performance Improvement (QAPI) – Access	44	35	5	3	1
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	21	21	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	32	23	9	0	0

Humana Health Plan: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
Grievance System	▪ Notice of Action contains the action taken or intended. Substantial Compliance: 3 of 20 UM files reviewed did not contain the Notice of Action. ▪ Notice of Action contains the reasons for the action. Substantial Compliance: 3 of 20 UM files reviewed did not contain the Notice of Action. ▪ Standard service authorization decisions are made within the timeframes specified. Substantial Compliance: 17 of 20 UM files were not timely. <u>Summary of Grievance File Review Findings (Total Files Reviewed: 20)</u>: ▪ Twenty grievance files were reviewed. ▪ All files were compliant with requirements. <u>Summary of Appeal File Review Findings (Total Files Reviewed: 20)</u>: ▪ Twenty appeal files were reviewed. ▪ All files were compliant with requirements. <u>Summary of Utilization Management File Review Findings (Total Files Reviewed: 20)</u>: ▪ Twenty UM files were reviewed. ▪ Three files did not contain a Notice of Action. ▪ Seventeen files were not timely. ▪ 2 medical necessity denials for continued inpatient stay did not contain evidence of consulting with requesting provider.
Enrollee Rights and Protections	▪ Notify members that oral interpretation services are available free of charge for all languages other than English. Substantial Compliance: Not found in the Uniform Guide for the Insured 2012. ▪ Notify members that oral interpretation is available for any language and written information is available for prevalent languages. Substantial Compliance: Not found in the Uniform Guide for the Insured 2012 ▪ Notify members of their right to request and obtain information specified by CMS under 438.10 at least once a year. Non-Compliance: Notifying enrollees annually is not addressed in the documents provided. ▪ MCO makes a good faith effort to give written notice of termination of a contracted provider within 15

Humana Health Plan: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	days after receipt or issuance of the termination notice. Substantial Compliance: Policies do not address the timeframe for notifying members. ▪ When enrollee requests that benefits continue when filing an appeal or request for SFH, the enrollee may be required to pay the cost of the services furnished if the final decision is adverse to the enrollee. Minimal Compliance: Evidence of communication of this right was not found in the P/P or Uniform Guide for the Insured. ▪ Providers have the right to appeal the failure of the organization to cover a service as defined by the State. Minimal Compliance: P/P does not address this. ▪ Written policies and procedures for Advance Directives, including all requirements – Substantial Compliance: No P/P regarding Advance Directives, though this is addressed in the Uniform Guide for the Insured.
Quality Assessment and Performance Improvement (QAPI) – Access	▪ MCO requires out-of-network providers to coordinate with respect to payment and ensures the cost to the enrollee is not greater than within the network. Substantial Compliance: Evidence of notification to out-of-network providers not found. ▪ Monitor providers for timely access regularly. Substantial Compliance: The MCO verbally reported conducting onsite audits of appointment availability, but no reports were provided. ▪ Takes corrective action for providers who do not comply with access and availability standards. Substantial Compliance: P/Ps were seen but results of monitoring were not provided. ▪ Share results of assessment of ISHCN with other MCOs to prevent duplication of services. Minimal Compliance: P/Ps do not address sharing information with other MCOs. ▪ Privacy is protected for those enrollees who are receiving coordination of care services. Substantial Compliance: Confidentiality P/Ps address medical records, but are not specific to coordination of care. ▪ Consulting with requesting providers regarding authorizations when appropriate. Substantial: 2 medical necessity denials for continued inpatient stay did not contain evidence of consulting with requesting provider. ▪ Decision to deny or reduce a service authorization request is made by a health care professional with appropriate clinical expertise. Minimal Compliance: Files contained only the name of the person making the decision with no credentials and denial letters did not contain the Medical Director signature, therefore, appropriate health care professional could not be determined. ▪ Standard authorization decisions are provided as expeditiously as the enrollee's condition requires and within established timeframes. Minimal Compliance: 17 of 20 files were not timely.

Humana Health Plan: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	▪ Contracts provide that compensation to individuals/entities that conduct UM functions is not structured so as to provide incentives to deny or limit medically necessary services. Non-Compliance: Not address in the documents provided. Summary of Care Management File Review Findings (Total Files Reviewed: 20): ▪ Twenty files were reviewed. ▪ 14 did not contain both an assessment and a treatment plan due to unable to contact. ▪ Of 6 files with an assessment and care plan, 3 did not demonstrate monitoring and update, also due to unable to contact.
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ All requirements Fully Compliant. Summary of Credentialing and Re-credentialing File Review Findings (Total Files Reviewed: 20): ▪ Ten PCP credentialing/re-credentialing files were reviewed. All files were compliant with requirements. ▪ Ten Specialist credentialing/re-credentialing files were reviewed. All files were compliant with requirements.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ Conduct performance improvement projects as described in CMS regulations. Substantial Compliance: The Medicaid PIPs were not included in the QIC discussion/minutes and not included in the QI Evaluation. ▪ MCOs…must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. Substantial Compliance: As per above element. ▪ Implementation of system interventions to achieve improvement in quality (PIPs). Substantial: Per above review element and interventions addressing barriers were not found for the Medicaid Chronic Kidney Disease (CKD) PIP. ▪ Evaluates of the effectiveness of the interventions. Substantial Compliance: Per above review element and no process measures to evaluate intervention effectiveness were found for the CKD PIP. ▪ Submits performance measurement data as described in CMS regulations. Substantial: the QI Program Description and the QI Work Plan did not include information on a Provider Satisfaction or EPSDT rates are Humana listed Provider Satisfaction Surveys as “NA “on its document submission. The EPSDT screening and participation rates report was not found. ▪ Ensures that data received from providers is accurate and complete. Substantial Compliance: Humana PR did not provide any documentation of quality measurement results of data received from providers

Humana Health Plan: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	and vendors for accuracy and completeness.

Humana Health Plan: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant	**Follow-Up Findings: Current Status**
Standard: Grievance System	
▪ Enrollee Right to request Fair Hearing and procedure to request a Fair Hearing Non – Compliance: Not addressed in letters in 10 UM files reviewed.	▪ 2013 Review Determination: Full Compliance
▪ The enrollee's right to have benefits continue pending resolution of appeal, how to request this, and circumstances in which the enrollee will be required to pay the costs of services Non-Compliance: Not addressed in P/P	▪ 2013 Review Determination: Minimal Compliance
▪ Provision of assistance to enrollees in completing forms and other procedural steps, including interpreter services, toll-free telephone numbers with TTY/TTD and interpreter services Substantial Compliance: Not addressed in P/P but evident in file review.	▪ 2013 Review Determination: Full Compliance
▪ Oral inquiries seeking appeal are treated as appeals to establish the date of filing and must be confirmed in writing, unless an expedited appeal is requested Substantial Compliance: Not addressed in P/P but evident in file review. Per HHP response, P/P G&A 08-001 has been updated to address this requirement.	▪ 2013 Review Determination: Full Compliance
▪ Timeliness of standard appeal resolution not greater than 45 days (except if an extension is requested) Substantial Compliance: One provider appeal file not compliant.	▪ 2013 Review Determination: Full Compliance
▪ Exceptions to mailing advance notice of action at least 10 days prior Non-Compliance: Not addressed in documents provided.	▪ 2013 Review Determination: Full Compliance
▪ The period of advance notice may be shortened to 5 days if the MCO has verified cause to suspect probable fraud Non-Compliance: Not addressed in documents provided.	▪ 2013 Review Determination: Full Compliance
<u>Summary of Appeal File Review Findings (Total Files Reviewed: 17)</u>: ▪ Ten member appeal files were reviewed. ▪ Seven provider appeal files were reviewed. One file was not timely.	▪ 2013 Review Determination: Full Compliance
<u>Summary of Utilization Management File Review Findings (Total Files Reviewed: 10)</u>:	<u>Summary of Utilization Management File Review Findings (Total Files Reviewed: 20)</u>:

Humana Health Plan: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant	**Follow-Up Findings: Current Status**
▪ Ten UM files were reviewed. ▪ None of the files were compliant with requirements for the enrollee's right to State Fair Hearing and how to request this	▪ Twenty UM files were reviewed. ▪ All files were compliant with requirements for the enrollee's right to State Fair Hearing and how to request this. ▪ 17 of 20 files were not timely ▪ 2 medical necessity denials for continued inpatient stay did not contain evidence of consulting with requesting provider.
Enrollee Rights and Protections	
▪ Written policies and procedures for Advance Directives, including all requirements Substantial Compliance: No evidence of community outreach or education activities regarding Advance Directives; however, information regarding Advance Directives is evident in policies and procedures, patient manual, and provider handbook.	▪ 2013 Review Determination: Substantial Compliance No P/P regarding Advance Directives, though this is addressed in the Uniform Guide for the Insured.
Quality Assessment and Performance Improvement (QAPI) – Access	
▪ Treatment plan – Substantial Compliance: Not addressed in 3 files received. <u>Summary of Care Management File Review Findings (Total Files Reviewed: 10)</u>: ▪ Ten files were reviewed. ▪ Three files were not compliant with requirements to produce a treatment plan for enrollees with special health care needs.	▪ 2013 Review Determination: Full Compliance
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	
▪ Evidence of distribution of clinical guidelines to providers and members Substantial Compliance: Documentation provided does not address how guidelines are made available to members.	▪ 2013 Review Determination: Full Compliance
▪ General requirements for QAPI program Minimal Compliance: 2010 QI Evaluation does not explicitly discuss PIP results; QI Work Plan sections for results, actions, assessment, analysis, and barriers are not completed on the documents provided. QI Committee minutes evidence minimal discussion of PIPs and CAHPS. QI Committee	▪ 2013 Review Determination: Full Compliance

Humana Health Plan: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant	**Follow-Up Findings: Current Status**
minutes do not reflect the responsibilities and functions stated in the P/P, including: review and analysis, and priority setting.	
▪ The MCO ensures data received from providers is accurate and complete Substantial Compliance: method for ensuring provider data is complete and accurate is not evident from documents provided.	▪ 2013 Review Determination: Substantial Compliance Humana PR did not provide any documentation of quality measurement results of data received from providers and vendors for accuracy and completeness.
▪ The MCO verifies the accuracy and timeliness of data Substantial Compliance: It is not clear how data received from providers is validated.	▪ 2013 Review Determination: Substantial Compliance Humana PR did not provide any documentation of quality measurement results of data received from providers and vendors for accuracy and completeness.

Triple S Medicaid Compliance Review Findings for Contract Year 2012-2013

A summary of the Medicaid compliance results for Triple S is provided below. For each standard, the following is provided: current year overall category compliance designations; a description of the current year findings for all standards/elements not found fully compliant, including a summary of the file review results. Since this was the first review for Triple S Medicaid/Mi Salud! There are no prior findings to compare to the current findings and assess the plan's progress.

Triple S: Summary of 2014 Medicaid Managed Care Compliance Review Findings (Review Year 2012/2013)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	48	35	13	0	0
Enrollee Rights and Protections	49	48	0	0	1
Quality Assessment and Performance Improvement (QAPI) – Access	45	39	4	0	2
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	21	21	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	32	10	10	11	1

Triple S: 2014 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
Grievance System	▪ The enrollee or the provider may file an appeal either orally or in writing, and…unless he or she requests expedited resolution; must follow an oral filing with a written, signed appeal. Substantial Compliance: The Member Handbook does not include requirement for member to follow oral filing with written signed appeal. ▪ The notice must be in writing and must meet the language and format requirements…to ensure ease of understanding (Notice of Action requirement). Substantial Compliance: For 3 of 20 UM denial files reviewed, the notice of action was not written in a manner and format easily understood by the member. ▪ The enrollee's or the provider's right to file an MCO or PIHP appeal (Notice of Action requirement). Substantial Compliance: For 4 of 20 UM denial files reviewed, the notice of action did not contain the enrollee's or provider's right to appeal. ▪ If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing (Notice of Action requirement). Substantial Compliance: 4 of 20 UM denial files reviewed, the notice of action did not contain the right to SFH. ▪ The procedures for exercising the rights (to appeal and/or SFH) specified in this paragraph (Notice of Action requirement). Substantial Compliance: 4 of 20 UM denial files reviewed, the notice of action did not contain the procedures for requesting an appeal or SFH. ▪ The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services (Notice of Action Requirement). Substantial Compliance: 4 of 20 UM denial files reviewed, the notice of action did not contain the right for benefits to continue, how to request, and possible financial liability. ▪ Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. ▪ MCO must acknowledge receipt of each grievance and appeal. Substantial Compliance: For 2 of 20 grievance files reviewed, an acknowledgment letter was not found. For all appeal files reviewed, none contained an acknowledgement letter, though this would not apply for the appeals that were resolved within 3 days. ▪ The results of the resolution process and the date it was completed. Substantial Compliance: None of the 20 appeals files reviewed contained a copy of the resolution letter. Though the system noted

Triple S: 2014 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	letters were sent, it was not possible to verify the contents of the notices. Template letter is compliant. ▪ For appeals not decided wholly in favor of the member, the notice of resolution contains the right to request a State fair hearing, and how to do so (appeal resolution notice requirement). Substantial Compliance: None of 20 appeals files reviewed contained a resolution notice, therefore, it could not be determined if enrollees were notified of the right to request a SFH and how to do so. P/P and letter template were compliant. ▪ The notice of resolution must contain the right of the enrollee to request to receive benefits while the hearing is pending, and how to make the request; and that the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the MCO's…action. Substantial Compliance: None of 20 appeals files reviewed contained a resolution notice, therefore, it could not be determined if enrollees were notified of the right to request continuation of benefits and possible financial liability. P/P and letter template were compliant. ▪ The MCO or PIHP must provide the information specified…about the grievance system to all providers and subcontractors at the time they enter into a contract. Substantial Compliance: This requirement was not addressed in policy/procedure documents provided. The Provider Manual communicates this requirement. <u>Summary of Grievance File Review Findings (Total Files Reviewed: 20)</u>: ▪ Twenty grievance files were reviewed (10 member and 10 provider). ▪ For 2 of 20 files reviewed, an acknowledgement letter was not found. <u>Summary of Appeals File Review Findings (Total Files Reviewed: 20)</u>: ▪ Twenty appeals files were reviewed (10 member and 10 provider). ▪ None of the files contained an acknowledgement letter; however, this would not be applicable to appeals resolved within 3 days. ▪ None of the files reviewed contained a resolution letter. The system indicated that letters were generated, but the contents of the letters could not be confirmed. ▪ None of the files reviewed contained a resolution letter, therefore, information on the enrollee right to SFH could not be confirmed. ▪ None of the files reviewed contained a resolution notice, therefore, information on the enrollee's right to request continuation of benefits and possible financial liability could not be confirmed. <u>Summary of Utilization Management File Review Findings (Total Files Reviewed: 20)</u>

Triple S: 2014 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	▪ Twenty utilization management files were reviewed. ▪ For 3 of 20 UM denial files reviewed, the notice of action was not written in a manner and format easily understood by the member. ▪ For 4 of 20 UM denial files reviewed, the notice of action did not contain the enrollee's or provider's right to appeal. ▪ For 4 of 20 UM denial files reviewed, the notice of action did not contain the right to SFH. ▪ For 4 of 20 UM denial files reviewed, the notice of action did not contain the procedures for requesting an appeal or SFH. ▪ For 4 of 20 UM denial files reviewed, the notice of action did not contain the right for benefits to continue, how to request, and possible financial liability.
Enrollee Rights and Protections	▪ All requirements were fully compliant.
Quality Assessment and Performance Improvement (QAPI) – Access	▪ MCO… must implement mechanisms to assess each Medicaid enrollee…having special health care needs to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. Substantial Compliance: 1 of 20 care management files reviewed did not contain an assessment. ▪ Enrollees with special health care needs…the MCO… must allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs. Substantial Compliance: Not addressed in policy/procedure. The Member Handbook informs enrollees how to access specialists. <u>Summary of Care Management File Review Findings (Total Files Reviewed: 20)</u> ▪ Twenty case management files were reviewed. ▪ One of 20 files did not contain an assessment.
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ All review elements were fully compliant. <u>Summary of Credentialing & Re-credentialing Review Findings (Total Files Reviewed: 12)</u> ▪ A total of 20 credentialing and re-credentialing files were reviewed (10 PCPs and 10 specialists). ▪ All files reviewed met the requirements.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ Each MCO…adopts practice guidelines. Substantial Compliance: A policy/procedure for adoption of clinical practice guidelines was not provided. ▪ Guidelines are based on valid and reliable clinical evidence or a consensus of health care

Triple S: 2014 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	professionals in the particular field. Substantial Compliance: Triple S cited local and national sources for CPGS, however, a P/P defining the process and stating sources was not provided. ▪ Guidelines consider the needs of the MCO's…enrollees. Substantial Compliance: A specific policy describing the plan's process for adopting/developing guidelines, including how needs of members are considered, was not provided. ▪ Guidelines are adopted in consultation with contracting health care professionals. Minimal Compliance: A specific policy describing the plan's process for adopting/developing guidelines, including how input from providers is incorporated, was not provided. ▪ Guidelines are reviewed and updated periodically as appropriate. Substantial Compliance: A specific policy describing the plan's process for adopting/developing guidelines, including the process and timeframes for review and revision, was not provided. ▪ The MCO must have an ongoing quality assessment and performance improvement program. Substantial Compliance: There is no individual QI Work Plan document. Activities and timeframes are described in as part of the QAPI Program. No work plan updates were provided and no barrier analyses were evident in the documentation provided. ▪ Conduct performance improvement projects designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction. Substantial Compliance: PIPs showed varying degrees of success – some demonstrated improvement and for others, rates declined. It was noted that all members in baseline were included in the remeasurement, even if member was no longer enrolled. This is not methodologically correct. ▪ The MCO must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. Minimal Compliance: Documentation provided does not show evidence of analysis or actions taken specific to special needs populations. ▪ Performance Improvement Projects include an evaluation of the effectiveness of the interventions – Substantial Compliance: Some improvement was seen and some PIP measure rates declined. No evidence of barrier analysis or re-evaluation and subsequent revision of interventions was found in the PIP reports. ▪ PIPs include planning and initiation of activities for increasing or sustaining improvement. Minimal Compliance: No evidence of barrier analysis or re-evaluation and subsequent revision of interventions were found in the PIP reports.

Triple S: 2014 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	▪ Each MCO … must report the status and results of each project to the State as requested. Non-Compliance: Evidence of submission of PIPs to ASES not provided. ▪ The State must review, at least annually, the impact and effectiveness of each MCO's… quality assessment and performance improvement program. Minimal Compliance: The 2012 QI Evaluation addressed Medicare and Commercial product lines, but not Medicaid/Mi Salud! ▪ The MCO reports performance on the standard measures as required. Minimal Compliance: The 2012 QI Evaluation addressed Medicare and Commercial product lines, but not Medicaid/Mi Salud! ▪ The MCO has in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. Minimal Compliance: The 2012 QI Evaluation addressed Medicare and Commercial product lines, but not Medicaid/Mi Salud! ▪ MCO…maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on utilization, grievances and appeals, and disenrollments. Minimal Compliance: Policy/procedure for collecting, producing and submitting encounter data was not provided. ▪ The MCO must collect data on enrollee and provider characteristics, and on services furnished to enrollees through an encounter data system. Minimal Compliance: Policy/procedure for collecting, producing and submitting encounter data was not provided. ▪ Ensure that data received from providers is accurate and complete. Substantial Compliance: Reports demonstrating results not provided. ▪ The MCO must have a process for verifying the accuracy and timeliness of reported data. Substantial Compliance: Reports demonstrating monitoring the accuracy and timeliness of reported data were not provided. ▪ The MCO must have a process for screening the data for completeness, logic, and consistency. Substantial Compliance: Reports demonstrating screening for completeness, logic, and consistency of reported data were not provided. ▪ The MCO must have a process for collecting service information in standardized formats to the extent feasible and appropriate. Minimal Compliance: Policy/procedure for collecting, producing and submitting encounter data was not provided. ▪ The MCO must make all collected data available to the State and upon request to CMS. Minimal Compliance: Evidence of submitting encounter data to ASES was not provided.

Validation of Performance Measures

This section of the report summarizes the Medicaid MCOs'/PIHPs' reporting of select performance measures, as well as HEDIS audit results and recommendations for developing and continuing interventions to improve care based on its HEDIS results.

PRHIA Requirements for Performance Measure Reporting

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

The PRHIA selected the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee of Quality Assurance (NCQA) as the required performance measures. For the 2011 EQR evaluation, the PRHIA required all health plans to collect and report HEDIS 2011 non-survey measures that reflect the services rendered to their Medicaid enrollees during 2010. The health plans were required to submit their final rates to IPRO, the Commonwealth's licensed HEDIS organization, by NCQA's Medicaid reporting deadline of June 15, 2011. However, based on contracting delays, the MCO's were given an extension to December 15, 2011. For HEDIS 2012 and HEDIS 2013, IPRO was not under contract for this review and as such the results are unaudited.

IPRO's Objectives for Validation of PMs

For this mandatory activity IPRO integrated the HEDIS 2011 through HEDIS 2013 rates for all the Medicaid managed care organizations for Puerto Rico into this Technical Report. The health plans' rates are compared to the *NCQA HEDIS 2011-2013 National Medicaid Benchmarks.*

NCQA HEDIS® 2011 Compliance Audit

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

As part of the HEDIS® 2011 Compliance Audit, auditors assessed compliance with NCQA standards in the six designated Information Systems (IS) categories, as follows:

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

In addition, the following HEDIS® Measure Determination (HD) standards categories were assessed:

- **HD 1.0:** Denominator Identification
- **HD 2.0:** Sampling
- **HD 3.0:** Numerator Identification

- **HD 4.0:** Algorithmic Compliance
- **HD 5.0:** Outsourced or Delegated HEDIS® Reporting Functions

PRHIA required 18 Physical Health HEDIS measures and 6 Behavioral Health HEDIS measures for reporting by the MCOs/PIHPs. This is a subset of the complete requirements. APS was responsible for reporting the behavioral health measures.

Prevention and Screening
- Adult BMI Assessment (ABA)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)
- Childhood Immunization Status (CIS)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Chlamydia Screening in Women (CHL)

Respiratory Conditions
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Use of Appropriate Medications for People with Asthma (ASM)

Cardiovascular
- Cholesterol Management for Patients with Cardiovascular Conditions (CMC)
- Controlling High Blood Pressure (CBP)

Diabetes
- Comprehensive Diabetes Care (CDC)

Access /Availability of Care
- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Children and Adolescents ' Access to Primary Care Practitioners (CAP)
- Annual Dental Visit (ADV)
- Prenatal and Postpartum Care (PPC)

Use of Services
- Frequency of Ongoing Prenatal Care (FPC)
- Well-Child Visits in the First 15 Months of Life (W15)
- Adolescent Well Care Visits (AWC)

Behavioral Health
- Antidepressant Medication Management (AMM)
- Follow-up Care for Children Prescribed ADHD Medication (ADD)
- Follow-up After Hospitalization for Mental Illness (FUH)
- Mental Health Utilization (MPT)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- Identification of Alcohol and Other Drug Services (IAD)

Description of Data Obtained

The tables on the following pages show the HEDIS 2011 – 2013 results for both the physical health and behavioral health measures. Rates that are highlighted in GREEN were above the NCQA National Mean for their respective year.

For HEDIS 2011, MCS provided benefits to members in the: Northeast, MetroNorth, North, San Juan, and West. Humana provided services for: East, Southeast and South West.

HEDIS 2011 Measure/Data Element	NORTHEAST	METRONORTH	NORTH	SAN JUAN	WEST	EAST	SOUTHEAST	SOUTHWEST
Effectiveness of Care: Prevention and Screening								
Adult BMI Assessment (aba)	29.93%	NP	NP	4.14%	26.52%	7.79%	9.49%	9.73%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)								
BMI Percentile	**38.20%**	NP	NP	10.95%	12.41%	2.68%	4.62%	7.54%
Counseling for Nutrition	**50.61%**	NP	NP	15.33%	12.65%	8.52%	8.52%	11.92%
Counseling for Physical Activity	**36.74%**	NP	NP	9.00%	5.60%	3.89%	4.38%	3.16%
Childhood Immunization Status (cis)								
DTaP	30.41%	NP	NP	20.92%	37.96%	46.47%	58.64%	59.85%
IPV	45.01%	NP	NP	27.98%	58.15%	60.83%	72.99%	72.02%
MMR	81.27%	NP	NP	88.08%	90.02%	71.53%	76.40%	83.45%
HiB	45.74%	NP	NP	48.18%	66.18%	47.45%	60.10%	52.80%
Hepatitis B	39.42%	NP	NP	22.14%	39.42%	54.74%	67.88%	72.51%
VZV	82.97%	NP	NP	86.62%	90.02%	68.61%	76.64%	81.75%
Pneumococcal Conjugate	27.74%	NP	NP	19.71%	42.09%	40.15%	54.99%	54.01%
Hepatitis A	**51.58%**	NP	NP	**61.07%**	**56.45%**	34.79%	**46.23%**	**45.50%**
Rotavirus	15.33%	NP	NP	15.09%	11.44%	15.82%	28.95%	25.30%
Influenza	2.92%	NP	NP	1.22%	8.27%	6.81%	12.41%	11.92%
Combination #2	22.14%	NP	NP	9.25%	19.22%	31.14%	39.90%	38.69%
Combination #3	17.52%	NP	NP	6.08%	16.79%	26.28%	34.79%	33.09%
Combination #4	13.38%	NP	NP	5.60%	14.11%	17.76%	26.28%	24.57%
Combination #5	6.33%	NP	NP	3.41%	3.89%	8.03%	15.82%	12.90%
Combination #6	1.22%	NP	NP	0.24%	1.22%	2.68%	5.60%	6.08%
Combination #7	4.87%	NP	NP	3.16%	3.65%	4.38%	11.44%	9.98%
Combination #8	0.73%	NP	NP	0.24%	1.22%	2.19%	4.87%	5.35%
Combination #9	0.24%	NP	NP	0.24%	0.49%	0.73%	3.16%	2.92%

HEDIS 2011 Measure/Data Element	NORTHEAST	METRONORTH	NORTH	SAN JUAN	WEST	EAST	SOUTHEAST	SOUTHWEST
Combination #10	0.00%	NP	NP	0.24%	0.49%	0.73%	2.92%	2.43%
Breast Cancer Screening (bcs)	**52.85%**	NP	NP	50.86%	50.20%	**60.91%**	**54.14%**	31.05%
Cervical Cancer Screening (ccs)	55.23%	NP	NP	62.29%	53.28%	63.26%	65.21%	24.82%
Chlamydia Screening in Women (chl)								
16-20 Years	47.43%	NP	NP	46.32%	50.33%	39.64%	35.58%	36.07%
21-24 Years	44.36%	NP	NP	43.87%	50.25%	37.87%	35.97%	37.85%
Total	45.75%	NP	NP	45.03%	50.28%	38.66%	35.79%	37.13%
Effectiveness of Care: Respiratory Conditions								
Appropriate Treatment for Children With URI (uri)	80.39%	NP	NP	80.27%	83.21%	74.57%	63.16%	**94.59%**
Use of Appropriate Medications for People With Asthma (asm)								
5-11 years	74.78%	NP	NP	67.44%	50.60%	76.24%	76.76%	40.43%
12-50 years	67.22%	NP	NP	66.41%	53.73%	72.14%	71.75%	53.23%
12-18 years	NP	NP	NP	NP	NP	NP	NP	NP
19-50 years	NP	NP	NP	NP	NP	NP	NP	NP
51-64 years	NP	NP	NP	NP	NP	NP	NP	NP
Total	69.88%	NP	NP	66.73%	52.82%	73.63%	73.33%	49.71%
Effectiveness of Care: Cardiovascular								
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)								
LDL-C Screening Performed	57.74%	NP	NP	59.67%	32.85%	70.56%	74.94%	45.89%
Controlling High Blood Pressure (cbp)	46.23%	NP	NP	48.66%	36.74%	47.20%	45.26%	45.74%
Effectiveness of Care: Diabetes								
Comprehensive Diabetes Care (cdc)								
Hemoglobin A1c (HbA1c) Testing	48.81%	NP	NP	46.53%	31.57%	65.88%	57.85%	46.35%
Eye Exam (Retinal) Performed	13.32%	NP	NP	17.52%	12.59%	22.08%	16.79%	3.83%
LDL-C Screening Performed	39.96%	NP	NP	39.05%	20.99%	62.41%	60.04%	41.24%
Medical Attention for Nephropathy	65.69%	NP	NP	68.61%	56.93%	74.82%	70.99%	57.85%
Access/Availability of Care								
Adults' Access to Preventive/Ambulatory Health Services (aap)								
20-44 Years	49.83%	NP	NP	62.51%	47.19%	53.18%	51.29%	44.93%
45-64 Years	67.54%	NP	NP	77.86%	64.10%	68.41%	64.87%	61.70%
65+ Years	65.13%	NP	NP	76.23%	65.67%	65.86%	68.81%	48.92%

HEDIS 2011 Measure/Data Element	NORTHEAST	METRONORTH	NORTH	SAN JUAN	WEST	EAST	SOUTHEAST	SOUTHWEST
Total	NP	NP	NP	NP	NP	NP	NP	
Children and Adolescents' Access to Primary Care Practitioners (cap)								
12-24 Months	61.98%	NP	NP	84.38%	79.03%	70.30%	69.11%	81.19%
25 Months - 6 Years	52.98%	NP	NP	77.33%	70.74%	63.09%	62.11%	68.43%
7-11 Years	54.44%	NP	NP	81.18%	75.49%	67.22%	63.60%	68.50%
12-19 Years	47.38%	NP	NP	71.92%	62.04%	58.97%	60.49%	56.62%
Annual Dental Visit (ADV)	**51.40%**	NP	NP	**51.07%**	**51.89%**	**52.14%**	**48.62%**	12.50%
Prenatal and Postpartum Care (ppc)								
Timeliness of Prenatal Care	71.78%	NP	NP	64.72%	74.21%	68.13%	74.45%	76.23%
Postpartum Care	15.57%	NP	NP	15.57%	15.09%	28.71%	31.63%	22.95%
Use of Services								
Frequency of Prenatal Care (fpc)								
< 21 % of EV	4.87%	NP	NP	**10.71%**	6.57%	1.99%	2.27%	7.38%
21-40% of EV	5.11%	NP	NP	**7.54%**	**7.06%**	4.95%	5.90%	**13.93%**
41-60 % of EV	**16.79%**	NP	NP	**14.11%**	**15.09%**	**18.61%**	**20.51%**	**29.10%**
61-80 % of EV	**28.71%**	NP	NP	**26.76%**	**32.12%**	**27.37%**	**31.97%**	**28.69%**
> 80% of EV	44.53%	NP	NP	40.88%	39.17%	47.08%	39.36%	20.90%
Well-Child Visits in the First 15 Months of Life (w15)								
0 Visits	**60.10%**	NP	NP	**37.71%**	**67.15%**	**82.51%**	**89.89%**	**91.89%**
1 Visit	**20.68%**	NP	NP	**22.87%**	**16.30%**	**9.23%**	**5.92%**	**5.93%**
2 Visits	**6.57%**	NP	NP	**15.09%**	**4.38%**	**4.28%**	1.72%	1.62%
3 Visits	4.62%	NP	NP	**8.52%**	5.35%	1.41%	1.08%	0.39%
4 Visits	3.16%	NP	NP	7.06%	3.89%	1.41%	0.70%	0.11%
5 Visits	1.46%	NP	NP	4.38%	1.46%	0.90%	0.38%	0.06%
6+ Visits	3.41%	NP	NP	4.38%	1.46%	0.26%	0.32%	0.00%
Adolescent Well-Care Visits (awc)	15.82%	NP	NP	12.90%	6.08%	10.59%	13.96%	10.39%

NP: not provided

For HEDIS 2012, Triple S provided benefits to members in the: Northeast, MetroNorth, North, San Juan, West and Virtual. Humana provided services for: East, Southeast and Southwest.

HEDIS 2012 Measure/Data Element	NORTHEAST	METRONORTH	NORTH	SAN JUAN	WEST	EAST	SOUTHEAST	SOUTHWEST	VIRTUAL
Effectiveness of Care: Prevention and Screening									
Adult BMI Assessment (aba)	13.14%	13.38%	27.98%	21.90%	37.23%	21.17%	14.11%	12.78%	0.00%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)									
BMI Percentile	10.71%	2.92%	0.49%	11.92%	13.38%	9.25%	7.06%	14.36%	4.69%
Counseling for Nutrition	8.76%	9.00%	20.92%	19.46%	10.22%	18.49%	16.79%	11.19%	7.81%
Counseling for Physical Activity	8.27%	3.89%	11.44%	10.46%	4.14%	8.52%	8.27%	4.14%	1.56%
Childhood Immunization Status (cis)									
DTaP	30.90%	48.18%	54.01%	59.61%	59.85%	47.20%	44.04%	47.32%	0.00%
IPV	57.18%	70.80%	72.02%	76.40%	73.72%	60.34%	55.96%	55.85%	0.00%
MMR	80.54%	84.91%	79.08%	88.32%	88.56%	71.53%	69.59%	84.88%	50.00%
HiB	49.64%	72.26%	72.26%	75.43%	71.78%	65.45%	61.80%	59.02%	0.00%
Hepatitis B	42.58%	49.15%	57.42%	63.26%	65.69%	49.64%	50.60%	52.93%	0.00%
VZV	77.62%	80.29%	77.37%	83.21%	84.67%	65.69%	68.37%	79.51%	50.00%
Pneumococcal Conjugate	23.11%	36.01%	40.88%	46.72%	50.36%	41.36%	40.15%	41.71%	0.00%
Hepatitis A	**48.91%**	**49.15%**	**43.80%**	**51.34%**	**51.34%**	**40.15%**	**44.28%**	**41.46%**	**50.00%**
Rotavirus	18.25%	23.84%	34.06%	33.09%	50.12%	19.71%	26.28%	25.61%	0.00%
Influenza	3.65%	2.68%	5.11%	4.38%	6.57%	2.92%	5.35%	9.21%	0.00%
Combination #2	23.36%	30.17%	42.09%	47.45%	50.61%	NP	NP	NP	0.00%
Combination #3	17.76%	23.36%	30.41%	39.42%	43.55%	NP	NP	NP	0.00%
Combination #4	13.87%	17.52%	19.46%	29.44%	30.66%	NP	NP	NP	0.00%
Combination #5	5.60%	8.27%	13.63%	19.95%	30.66%	NP	NP	NP	0.00%
Combination #6	1.22%	1.46%	2.19%	3.16%	2.68%	NP	NP	NP	0.00%
Combination #7	4.38%	6.33%	8.76%	16.06%	22.63%	NP	NP	NP	0.00%
Combination #8	0.97%	1.22%	1.95%	3.16%	1.70%	NP	NP	NP	0.00%
Combination #9	0.00%	0.24%	1.22%	1.70%	2.43%	NP	NP	NP	0.00%
Combination #10	0.00%	0.24%	1.22%	1.70%	1.70%	NP	NP	NP	0.00%
Breast Cancer Screening (bcs)	42.03%	47.46%	46.52%	41.72%	42.23%	**60.51%**	**54.04%**	44.23%	0.00%
Cervical Cancer Screening (ccs)	35.04%	40.88%	48.18%	38.69%	39.90%	57.84%	54.32%	25.11%	**75.00%**

HEDIS 2012 Measure/Data Element	NORTHEAST	METRONORTH	NORTH	SAN JUAN	WEST	EAST	SOUTHEAST	SOUTHWEST	VIRTUAL
Chlamydia Screening in Women (chl)									
16-20 Years	27.65%	28.10%	30.43%	28.51%	33.95%	NP			14.29%
21-24 Years	26.96%	27.67%	28.37%	28.07%	32.59%	NP			0.00%
Total	27.27%	27.87%	29.28%	28.27%	33.18%	38.82%	37.77%	40.58%	12.50%
Effectiveness of Care: Respiratory Conditions									
Appropriate Treatment for Children With URI (uri)	81.29%	79.51%	78.93%	81.70%	82.13%	22.57%	36.30%	32.63%	0.00%
Use of Appropriate Medications for People With Asthma (asm)									
5-11 years	79.15%	86.49%	73.62%	68.93%	58.49%	NP	NP	NP	0.00%
12-50 years	NP	NP	NP	NP	NP	NP	NP	NP	NP
12-18 years	79.15%	86.49%	73.62%	68.93%	58.49%	NP	NP	NP	0.00%
19-50 years	**79.15%**	**86.49%**	73.62%	68.93%	58.49%	NP	NP	NP	0.00%
51-64 years	**79.41%**	**83.33%**	**78.52%**	65.52%	58.16%	NP	NP	NP	**100.00%**
Total	70.74%	76.40%	74.72%	68.61%	63.21%	75.34%	70.48%	62.50%	**100.00%**
Effectiveness of Care: Cardiovascular									
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)									
LDL-C Screening Performed	45.86%	62.53%	57.66%	53.66%	34.55%	72.99%	74.70%	**100.00%**	0.00%
Controlling High Blood Pressure (cbp)	19.22%	25.79%	45.50%	43.31%	42.82%	44.53%	49.64%	45.99%	0.00%
Effectiveness of Care: Diabetes									
Comprehensive Diabetes Care (cdc)									
Hemoglobin A1c (HbA1c) Testing	42.15%	44.71%	56.20%	51.46%	37.59%	62.59%	64.23%	58.58%	**100.00%**
Eye Exam (Retinal) Performed	12.96%	15.15%	12.96%	14.05%	11.68%	25.36%	21.72%	17.15%	0.00%
LDL-C Screening Performed	39.60%	45.26%	49.64%	41.79%	25.00%	63.14%	62.41%	55.66%	0.00%
Medical Attention for Nephropathy	68.80%	66.42%	65.69%	73.91%	65.69%	74.82%	75.73%	71.72%	0.00%
Access/Availability of Care									
Adults' Access to Preventive/Ambulatory Health Services (aap)									
20-44 Years	44.85%	52.94%	49.74%	54.52%	42.25%	54.48%	50.47%	54.82%	80.00%
45-64 Years	62.43%	67.81%	65.89%	72.92%	60.05%	70.26%	65.51%	72.72%	0.00%
65+ Years	61.46%	66.71%	66.72%	72.68%	61.77%	69.11%	68.34%	71.71%	0.00%
Total	52.84%	59.50%	57.17%	63.97%	50.44%	NP	NP	NP	80.00%

HEDIS 2012 Measure/Data Element	NORTHEAST	METRONORTH	NORTH	SAN JUAN	WEST	EAST	SOUTHEAST	SOUTHWEST	VIRTUAL
Children and Adolescents' Access to Primary Care Practitioners (cap)									
12-24 Months	56.25%	75.67%	66.91%	77.94%	75.32%	73.24%	61.34%	84.36%	78.57%
25 Months - 6 Years	50.12%	63.29%	54.67%	70.46%	62.56%	63.98%	54.00%	75.55%	63.93%
7-11 Years	55.28%	58.40%	53.00%	74.73%	69.39%	67.19%	56.54%	80.65%	64.29%
12-19 Years	46.30%	49.48%	46.44%	64.33%	55.39%	57.94%	50.60%	44.07%	48.39%
Annual Dental Visit (ADV)	42.04%	43.08%	**47.28%**	43.97%	43.51%	**52.44%**	**48.45%**	2.32%	32.30%
Prenatal and Postpartum Care (ppc)									
Timeliness of Prenatal Care	69.34%	78.35%	71.05%	70.07%	76.89%	33.33%	50.00%	33.33%	0.00%
Postpartum Care	10.71%	13.14%	11.92%	14.11%	13.63%	0.00%	50.00%	**66.67%**	0.00%
Use of Services									
Frequency of Prenatal Care (fpc)									
< 21 % of EV	7.06%	2.68%	2.43%	3.89%	6.33%	NP	NP	NP	0.00%
21-40% of EV	**7.54%**	3.16%	**7.06%**	**7.54%**	5.84%	NP	NP	NP	0.00%
41-60 % of EV	**15.82%**	**10.71%**	**16.30%**	**16.30%**	**10.46%**	NP	NP	NP	0.00%
61-80 % of EV	**27.74%**	**21.65%**	**32.12%**	**30.66%**	**40.88%**	NP	NP	NP	0.00%
> 80% of EV	41.85%	**61.80%**	42.09%	41.61%	36.50%	2.18%	2.05%	5.30%	0.00%
Well-Child Visits in the First 15 Months of Life (w15)									
0 Visits	**56.93%**	**57.91%**	**56.93%**	**30.90%**	**57.18%**	**68.36%**	**70.63%**	**52.22%**	0.00%
1 Visit	**26.28%**	**19.95%**	**13.38%**	**18.00%**	**25.30%**	**17.09%**	**12.52%**	**22.47%**	**100.00%**
2 Visits	**8.03%**	**10.46%**	**8.27%**	**12.17%**	**7.30%**	**7.52%**	**7.07%**	**13.92%**	0.00%
3 Visits	4.38%	4.87%	**7.06%**	**13.87%**	3.41%	3.77%	4.32%	3.48%	0.00%
4 Visits	2.92%	2.68%	6.08%	7.79%	2.68%	1.82%	3.39%	4.43%	0.00%
5 Visits	0.49%	1.22%	4.62%	6.57%	1.46%	7.90%	1.13%	1.58%	0.00%
6+ Visits	0.97%	2.92%	3.65%	10.71%	2.68%	0.65%	.93%	1.90%	0.00%
Adolescent Well-Care Visits (awc)	4.87%	13.87%	9.73%	15.82%	5.60%	8.26%	8.76%	12.56%	5.19%

NP: not provided

For HEDIS 2013, Triple S provided benefits to members in the: Northeast, MetroNorth, North, San Juan, West and Virtual. Humana provided services for: East, Southeast and Southwest.

HEDIS 2013 Measure/Data Element	NORTHEAST	METRONORTH	NORTH	SAN JUAN	WEST	EAST	SOUTHEAST	SOUTHWEST	VIRTUAL
Effectiveness of Care: Prevention and Screening									
Adult BMI Assessment (aba)	18.00%	21.41%	41.12%	18.73%	40.63%	30.65%	33.57%	34.79%	33.33%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)									
BMI Percentile	27.01%	2.92%	3.65%	6.57%	22.14%	3.89%	12.89%	16.30%	6.81%
Counseling for Nutrition	6.33%	3.41%	5.35%	3.89%	13.87%	18.00%	16.54%	24.81%	3.65%
Counseling for Physical Activity	1.95%	1.95%	4.14%	2.43%	5.84%	12.89%	8.51%	16.30%	2.68%
Childhood Immunization Status (cis)									
DTaP	34.79%	34.06%	62.29%	34.55%	37.96%	48.66%	46.22%	56.44%	32.79%
IPV	47.45%	44.53%	73.48%	46.23%	55.72%	58.15%	56.44%	65.20%	47.54%
MMR	81.02%	83.21%	88.81%	72.75%	83.70%	69.09%	70.07%	82.23%	72.13%
HiB	56.69%	59.85%	77.86%	58.15%	72.99%	63.74%	63.74%	68.36%	57.38%
Hepatitis B	40.39%	29.44%	66.42%	34.31%	27.49%	48.41%	52.79%	59.85%	37.70%
VZV	77.13%	79.56%	83.70%	68.86%	82.97%	68.12%	68.85%	80.53%	68.85%
Pneumococcal Conjugate	19.71%	12.90%	45.99%	20.92%	25.79%	43.30%	45.74%	51.09%	16.39%
Hepatitis A	**79.08%**	**78.10%**	**78.59%**	73.97%	**82.00%**	66.90%	69.58%	**77.12%**	**78.69%**
Rotavirus	53.04%	52.80%	61.07%	45.01%	51.34%	36.00%	36.73%	44.76%	31.15%
Influenza	3.89%	4.87%	14.11%	1.70%	4.87%	4.37%	9.73%	13.38%	4.92%
Combination #2	23.60%	14.84%	50.36%	22.38%	15.33%	NP	NP	NP	21.31%
Combination #3	15.33%	5.35%	38.69%	16.55%	11.92%	NP	NP	NP	11.48%
Combination #4	14.60%	5.35%	35.52%	15.57%	11.19%	NP	NP	NP	11.48%
Combination #5	13.38%	4.38%	28.95%	12.90%	9.25%	NP	NP	NP	8.20%
Combination #6	2.19%	0.97%	9.00%	0.73%	1.95%	NP	NP	NP	1.64%
Combination #7	12.90%	4.38%	26.52%	12.17%	8.52%	NP	NP	NP	8.20%
Combination #8	1.95%	0.97%	9.00%	0.73%	1.70%	NP	NP	NP	1.64%
Combination #9	2.19%	0.97%	5.84%	0.73%	1.46%	NP	NP	NP	1.64%
Combination #10	1.95%	0.97%	5.84%	0.73%	1.22%	NP	NP	NP	1.64%
Breast Cancer Screening (bcs)	48.87%	**52.54%**	**52.60%**	47.38%	47.78%	51.79%	**56.12%**	**54.21%**	**100.00%**
Cervical Cancer Screening (ccs)	43.07%	50.12%	48.66%	51.09%	47.93%	63.20%	58.78%	39.65%	40.00%

HEDIS 2013 Measure/Data Element	NORTHEAST	METRONORTH	NORTH	SAN JUAN	WEST	EAST	SOUTHEAST	SOUTHWEST	VIRTUAL
Chlamydia Screening in Women (chl)									
16-20 Years	43.19%	29.99%	34.92%	39.87%	40.06%	NP	NP	NP	47.25%
21-24 Years	41.35%	31.40%	37.88%	38.06%	44.56%	NP	NP	NP	50.00%
Total	42.17%	30.75%	36.55%	38.91%	42.60%	32.76%	31.11%	25.89%	47.29%
Effectiveness of Care: Respiratory Conditions									
Appropriate Treatment for Children With URI (uri)	81.69%	78.26%	78.98%	80.45%	84.11%	20.54%	36.81%	25.72%	78.38%
Use of Appropriate Medications for People With Asthma (asm)									
5-11 years	84.70%	87.50%	77.36%	78.10%	61.46%	NP	NP	NP	**100.00%**
12-50 years	NP	NP	NP	NP	NP	NP	NP	NP	NP
12-18 years	80.53%	84.15%	76.88%	64.52%	50.41%	NP	NP	NP	0.00%
19-50 years	63.55%	62.86%	66.98%	62.10%	51.88%	NP	NP	NP	**NA**
51-64 years	66.92%	64.74%	69.57%	63.49%	62.43%	NP	NP	NP	**NA**
Total	73.35%	74.31%	71.09%	67.13%	56.73%	79.81%	75.83%	77.38%	66.67%
Effectiveness of Care: Cardiovascular									
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)									
LDL-C Screening Performed	55.75%	73.48%	64.96%	62.06%	52.07%	76.88%	79.56%	67.63%	0.00%
Controlling High Blood Pressure (cbp)	17.03%	18.98%	48.42%	32.12%	32.12%	42.09%	54.01%	55.71%	33.33%
Effectiveness of Care: Diabetes									
Comprehensive Diabetes Care (cdc)									
Hemoglobin A1c (HbA1c) Testing	54.74%	61.68%	66.24%	52.19%	50.36%	67.63%	69.58%	64.72%	50.00%
Eye Exam (Retinal) Performed	16.06%	18.25%	17.70%	19.89%	16.24%	28.22%	23.11%	23.84%	8.33%
LDL-C Screening Performed	50.73%	60.04%	58.76%	45.44%	40.69%	66.90%	67.88%	63.99%	33.33%
Medical Attention for Nephropathy	72.63%	74.09%	70.62%	70.99%	68.98%	76.64%	75.66%	72.26%	8.33%
Access/Availability of Care									
Adults' Access to Preventive/Ambulatory Health Services (aap)									
20-44 Years	54.94%	59.45%	65.48%	58.71%	55.57%	62.20%	55.60%	56.00%	44.51%
45-64 Years	71.93%	74.36%	79.39%	75.71%	73.13%	76.03%	71.43%	74.40%	**100.00%**
65+ Years	71.91%	76.65%	82.10%	78.09%	77.05%	73.83%	73.98%	73.88%	0.00%
Total	62.45%	66.11%	71.82%	67.36%	63.64%	NP	NP	NP	44.67%

HEDIS 2013 Measure/Data Element	NORTHEAST	METRONORTH	NORTH	SAN JUAN	WEST	EAST	SOUTHEAST	SOUTHWEST	VIRTUAL
Children and Adolescents' Access to Primary Care Practitioners (cap)									
12-24 Months	19.03%	21.72%	21.67%	6.52%	60.79%	79.71%	67.83%	72.71%	51.30%
25 Months - 6 Years	14.18%	19.51%	14.66%	2.76%	52.93%	72.34%	59.28%	66.09%	49.50%
7-11 Years	43.11%	56.48%	49.00%	54.74%	65.82%	74.59%	59.78%	74.24%	46.79%
12-19 Years	37.36%	50.11%	45.07%	45.87%	54.20%	63.57%	51.98%	61.96%	47.64%
Annual Dental Visit (ADV)	**52.56%**	**54.69%**	**55.90%**	**53.21%**	**53.88%**	**54.44%**	**50.61%**	47.62%	**53.80%**
Prenatal and Postpartum Care (ppc)									
Timeliness of Prenatal Care	57.91%	64.48%	62.04%	58.88%	62.53%	59.12%	62.77%	63.74%	45.63%
Postpartum Care	16.30%	18.25%	26.52%	18.49%	17.76%	25.54%	22.14%	27.73%	17.48%
Use of Services									
Frequency of Prenatal Care (fpc)									
< 21 % of EV	10.71%	5.35%	7.79%	**13.14%**	9.00%	NP	NP	NP	**24.27%**
21-40% of EV	**13.63%**	**10.22%**	**13.63%**	**9.73%**	**9.00%**	NP	NP	NP	**10.68%**
41-60 % of EV	**21.65%**	**20.68%**	**20.92%**	**24.09%**	**26.52%**	NP	NP	NP	**19.42%**
61-80 % of EV	**27.25%**	**29.44%**	**27.74%**	**28.22%**	**35.52%**	NP	NP	NP	**25.24%**
> 80% of EV	26.76%	34.31%	29.93%	24.82%	19.95%	29.92%	21.65%	35.03%	20.39%
Well-Child Visits in the First 15 Months of Life (w15)									
0 Visits	**68.61%**	**65.94%**	**56.69%**	**59.37%**	**58.39%**	**58.34%**	**70.26%**	**52.35%**	**80.00%**
1 Visit	**18.49%**	**17.27%**	**20.92%**	**16.79%**	**23.84%**	**17.04%**	**13.75%**	**20.92%**	**6.67%**
2 Visits	**8.52%**	**7.30%**	**10.46%**	**10.95%**	**8.52%**	**9.92%**	**7.88%**	**11.60%**	**10.00%**
3 Visits	2.19%	**5.11%**	**5.35%**	**5.35%**	**5.35%**	**5.78%**	3.72%	**7.19%**	3.33%
4 Visits	1.46%	1.70%	3.41%	3.65%	1.46%	3.33%	2.51%	3.22%	0.00%
5 Visits	0.49%	1.22%	2.19%	1.95%	1.95%	2.12%	1.03%	2.08%	0.00%
6+ Visits	0.24%	1.46%	0.97%	1.95%	0.49%	3.46%	0.85%	2.63%	0.00%
Adolescent Well-Care Visits (awc)	4.14%	5.84%	6.57%	7.79%	7.06%	11.96%	9.37%	11.66%	4.38%

NA: not applicable; NP: not provided

The following tables reflect the behavioral health measures reported by APS. . Rates that are highlighted in GREEN were above the NCQA National Mean for their respective year.

2011 HEDIS Mental Health Measures	NORTH	METRONORTH	EAST	NORTHEAST	SOUTHEAST	SAN JUAN	SOUTHWEST	WEST
Follow up after hospitalization for mental illness (FUH)								
Follow-up after hospitalization for mental illness 7 days	**61.73%**	**61.45%**	**50.40%**	**62.69%**	**51.93%**	**51.63%**	**50.64%**	21.05%
Follow-up after hospitalization for mental illness 30 days	**79.51%**	**80.86%**	**74.49%**	**78.52%**	**78.70%**	**69.53%**	**71.79%**	52.15%
Follow-up care for children prescribed ADHD medication (ADD)								
Initiation Phase	**47.31%**	**41.30%**	35.25%	22.55%	**55.16%**	27.68%	0.00%	NP
Continuation and Maintenance Phase	**74.14%**	**64.29%**	**61.36%**	37.50%	**53.85%**	0.00%	0.00%	NP
Initiation and Engagement of Alcohol & Other Drug Dependence Treatment (IET)								
Initiation 13 - 17 years old	18.75%	13.64%	25.00%	**57.14%**	22.58%	25.00%	**52.17%**	**50.88%**
Initiation ≥ 18 years old	32.03%	27.37%	39.01%	**47.82%**	34.99%	39.56%	**55.54%**	34.64%
Initiation TOTAL	31.75%	26.91%	38.64%	**48.38%**	34.54%	39.29%	**55.42%**	35.77%
Engagement 13 - 17 years old	12.50%	4.55%	10.00%	**35.71%**	0.00%	12.50%	17.39%	**21.05%**
Engagement ≥ 18 years old	8.37%	5.38%	12.23%	**21.15%**	5.10%	7.77%	**15.41%**	10.07%
Engagement TOTAL	8.45%	5.35%	12.17%	**22.03%**	4.92%	7.86%	**15.48%**	10.83%
Antidepressant Medication Management (AMM)								
Effective Acute Phase 84 days	46.37%	39.04%	44.87%	38.71%	30.76%	46.92%	NP	**62.26%**
Effective Continuation Phase 180 days	30.73%	25.08%	27.69%	24.11%	22.07%	31.51%	NP	**34.91%**
Identification of Alcohol and other Drug Services (IAD)								
Any	0.64%	0.64%	0.76%	0.74%	0.20%	0.30%	0.24%	0.13%
Inpatient	0.00%	0.00%	0.00%	0.00%	0.05%	0.09%	0.04%	0.04%
IOP and Partial	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%
Outpatient and ED	0.64%	0.64%	0.75%	0.74%	0.16%	0.20%	0.20%	0.09%
Mental Health Utilization (MPT)								
Any	9.40%	**11.78%**	**10.14%**	8.00%	5.63%	9.48%	4.04%	2.82%
Inpatient	0.19%	0.33%	0.60%	0.32%	0.33%	0.43%	0.23%	0.19%
IOP and Partial	0.05%	0.12%	0.12%	0.04%	0.01%	0.15%	0.01%	0.01%
Outpatient and ED	9.17%	**11.33%**	9.42%	7.64%	5.29%	8.90%	3.80%	2.62%

NP: not provided

Behavioral Health HEDIS Measures - APS

2012 HEDIS Mental Health Measures	NORTH	METRONORTH	EAST	NORTHEAST	SOUTHEAST	SAN JUAN	SOUTHWEST	WEST
Follow up after hospitalization for mental illness (FUH)								
Follow-up after hospitalization for mental illness 7 days	**61.3%**	**62.1%**	**64.0%**	**59.6%**	**68.1%**	41.4%	**55.3%**	31.0%
Follow-up after hospitalization for mental illness 30 days	**78.0%**	**77.1%**	**78.6%**	**73.4%**	**80.1%**	56.4%	**71.6%**	42.3%
Follow-up care for children prescribed ADHD medication (ADD)								
Initiation Phase	**42.4%**	38.1%	36.8%	26.1%	37.3%	28.9%	**65.4%**	20.4%
Continuation and Maintenance Phase	**64.9%**	**69.4%**	**56.0%**	**61.5%**	**50.0%**	39.6%	**50.0%**	15.4%
Initiation and Engagement of Alcohol & Other Drug Dependence Treatment (IET)								
Initiation 13 - 17 years old	20.6%	27.3%	33.3%	**57.9%**	NP	**NA**	**NA**	25.5%
Initiation ≥ 18 years old	**40.4%**	**40.1%**	36.0%	**55.9%**	35.8%	38.7%	**46.4%**	36.1%
Initiation TOTAL	**39.8%**	**39.6%**	36.0%	**56.0%**	35.8%	38.3%	**45.9%**	35.5%
Engagement 13 - 17 years old	2.9%	4.5%	13.3%	**34.2%**	NP	**NA**	**NA**	9.1%
Engagement ≥ 18 years old	**16.2%**	**15.9%**	**15.6%**	**29.3%**	**17.8%**	11.3%	**23.8%**	11.3%
Engagement TOTAL	**15.8%**	**15.4%**	**15.5%**	**29.5%**	**17.8%**	11.2%	**23.3%**	11.2%
Antidepressant Medication Management (AMM)								
Effective Acute Phase 84 days	39.2%	39.7%	41.1%	34.9%	44.0%	36.6%	42.7%	42.9%
Effective Continuation Phase 180 days	20.8%	21.3%	21.5%	17.9%	22.9%	17.8%	21.4%	21.2%
Identification of Alcohol and other Drug Services (IAD)								
Any	0.85%	0.76%	0.96%	0.92%	0.79%	1.05%	0.74%	0.49%
Inpatient	0.07%	0.11%	0.16%	0.12%	0.14%	0.15%	0.11%	0.11%
IOP and Partial	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Outpatient and ED	0.83%	0.72%	0.89%	0.86%	0.71%	0.99%	0.69%	0.43%
Mental Health Utilization (MPT)								
Any	9.93%	**11.57%**	**10.76%**	8.47%	**11.48%**	8.29%	8.80%	6.70%
Inpatient	0.25%	0.38%	0.50%	0.37%	0.40%	0.52%	0.34%	0.26%
IOP and Partial	0.05%	0.06%	0.11%	0.04%	0.02%	0.07%	0.01%	0.01%
Outpatient and ED	9.88%	**11.51%**	**10.67%**	8.41%	**11.43%**	8.12%	8.75%	6.64%

NA; not applicable; NP: not provided

2013 HEDIS Mental Health Measures	NORTH	METRONORTH	EAST	NORTHEAST	SOUTHEAST	SAN JUAN	SOUTHWEST	WEST	VIRTUAL
Follow-up after hospitalization for mental illness (FUH)									
Follow-up after hospitalization for mental illness 7 days	**59.6%**	**47.8%**	**62.7%**	**50.1%**	**63.2%**	28.8%	**48.9%**	39.0%	**44.9%**
Follow-up after hospitalization for mental illness 30 days	**75.2%**	**66.5%**	**77.4%**	**68.2%**	**78.0%**	43.2%	**68.5%**	54.5%	**71.8%**
Follow-up care for children prescribed ADHD medication (ADD)									
Initiation Phase	**42.4%**	35.8%	29.3%	26.7%	**48.4%**	26.7%	**42.1%**	23.5%	**39.2%**
Continuation and Maintenance Phase	**64.9%**	**62.5%**	**47.5%**	**52.2%**	**68.1%**	**46.7%**	**76.9%**	40.5%	**55.9%**
Initiation and Engagement of Alcohol & Other Drug Dependence Treatment (IET)									
Initiation 13 - 17 years old	NP	29.3%	24.3%	**42.9%**	23.4%	NP	15.0%	23.4%	NP
Initiation ≥ 18 years old	34.8%	**42.1%**	36.6%	**52.0%**	36.6%	38.7%	**42.6%**	**41.5%**	NP
Initiation TOTAL	34.8%	**41.7%**	NP	**51.7%**	35.8%	38.7%	**41.7%**	**40.4%**	NP
Engagement 13 - 17 years old	NP	2.4%	10.8%	**28.6%**	6.4%	NP	5.0%	8.5%	NP
Engagement ≥ 18 years old	**17.3%**	**17.3%**	**16.2%**	**25.8%**	**12.5%**	**11.1%**	**23.6%**	**13.0%**	NP
Engagement TOTAL	**17.3%**	**16.8%**	NP	**25.8%**	**12.1%**	**11.1%**	**23.0%**	**12.7%**	NP
Antidepressant Medication Management (AMM)									
Effective Acute Phase 84 days	36.3%	37.7%	42.2%	36.1%	39.7%	32.8%	40.9%	41.5%	41.1%
Effective Continuation Phase 180 days	17.2%	18.5%	21.2%	17.2%	18.6%	16.8%	21.2%	21.9%	22.2%
Identification of Alcohol and other Drug Services (IAD)									
Any	0.88%	0.88%	0.90%	0.77%	0.63%	1.01%	0.70%	0.51%	1.60%
Inpatient	0.05%	0.09%	0.13%	0.11%	0.10%	0.12%	0.07%	0.07%	0.22%
IOP and Partial	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Outpatient and ED	0.86%	0.83%	0.85%	0.71%	0.58%	0.94%	0.67%	0.47%	1.47%
Mental Health Utilization (MPT)									
Any	10.30%	**12.21%**	10.02%	7.68%	9.89%	8.48%	7.74%	5.99%	**33.49%**
Inpatient	0.18%	0.30%	0.57%	0.27%	0.44%	0.35%	0.32%	0.23%	**1.27%**
IOP and Partial	0.08%	0.14%	0.22%	0.06%	0.04%	0.15%	0.02%	0.02%	0.16%
Outpatient and ED	10.26%	**12.17%**	9.86%	7.63%	9.83%	8.40%	7.69%	5.92%	**33.21%**

NP: not provided

Prevention and Screening

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

Findings: All regions reported rates below the NCQA mean for HEDIS 2011-2013.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) – The percentage of members 2–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Findings: All regions reported rates below the NCQA mean for HEDIS 2011-2013 with the exception of the Northeast that exceeded the HEDIS 2011 mean for all subpopulations.

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

Note: *Children must receive the required number of rotavirus vaccinations (two doses or three doses). The number of doses depends on which vaccine is given.*

Findings: The Hepatitis A vaccine was above the NCQA HEDIS mean for all three years with the exception of HEDIS 2013 in the San Juan, East and Southwest regions.

Breast Cancer Screening (BCS) – The percentage of women 40–69 years of age who had a mammogram to screen for breast cancer.

Findings: For HEDIS 2011 the Northeast, East and Southeast were above the NCQA mean. For HEDIS 2012, the East and Southeast were above the NCQA mean. In HEDIS 2013, the Metro North, North, Southeast, Southwest and Virtual regions were above the NCQA mean.

Cervical Cancer Screening (CCS) – The percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer.

Findings: Only the Virtual region for HEDIS 2012 was above the NCQA mean.

Chlamydia Screening in Women (CHL) – The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.

Findings: All regions reported rates below the NCQA mean for HEDIS 2011-2013.

Respiratory Conditions

Appropriate Treatment for Children with Upper Respiratory Infection (URI) – The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

Findings: Only the Southwest region for HEDIS 2011 was above the NCQA mean.

Use of Appropriate Medications for People with Asthma (ASM) – The percentage of members 5–50 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

Findings: For the combined measure, all regions were below the NCQA mean with the exception of the Virtual region for HEDIS 2012..

Cardiovascular

Cholesterol Management for Patients with Cardiovascular Conditions (CMC) – The percentage of members 18–75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1–November 1 of the year prior to the measurement year, *or* who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to measurement year, who had each of the following during the measurement year.

Findings: Only the Southwest region for HEDIS 2012 reported above the NCQA mean.

Controlling High Blood Pressure (CBP) – The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year.

Findings: All regions reported rates below the NCQA mean for HEDIS 2011-2013.

Diabetes

Comprehensive Diabetes Care (CDC) – The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following.

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- HbA1c control (<7.0%) *
- Eye exam (retinal) performed
- LDL-C screening
- LDL-C control (<100 mg/dL)
- Medical attention for nephropathy
- BP control (<130/80 mm Hg)
- BP control (<140/90 mm Hg)

Note: *For HbA1c Poor control, a lower rate indicates better performance.*

Findings: Only the Hemoglobin A1c rate for the virtual region for HEDIS 2012, was reported above the NCQA mean.

Access/Availability of Care

Adults' Access to Preventive/Ambulatory Health Services (AAP) – The percentage of members 20 years and older who had an ambulatory or preventive care visit.

Findings: All regions reported below the NCQA mean for all age subgroups with the exception of the Virtual region 45-64 rate which was above the NCQA mean.

Children and Adolescents' Access to Primary Care Practitioners (CAP) – The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages:

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

Findings: All regions reported rates below the NCQA mean.

Annual Dental Visit (ADV) – The percentage of members 2–21 years of age who had at least one dental visit during the measurement year.

Findings: For the HEDIS 2011 total rate, all regions that reported but the Southwest were above the NCAA mean. For HEDIS 2012, North, East and Southeast were above the NCQA mean. For HEDIS 2013, all regions but the Southwest were above the NCQA mean.

Prenatal and Postpartum Care (PPC) – The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

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

Findings: For both the Prenatal and Postpartum care measures, all regions reported below the NCQA mean for HEDIS 2011-2013 with the exception of the postpartum rate for the Southwest region for HEDIS 2012.

Use of Services

Frequency of Ongoing Prenatal Care (FPC) – The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits:

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

Findings: For the 81+ measure, all regions reported rates below the NCQA mean for HEDIS 2011-2013.

Well-Child Visits in the First 15 months of Life (W15) - The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life:

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

Findings: For the Six or more visits rate, all regions reported rates below the NCQA mean.

Adolescent Well-Child Visits (AWC) – The percentage of members 12-21 years of age who had at least one comprehensive well-child visit with a PCP or an OBG/GYN during the measurement year.

Findings: All plans reported rates below the NCQA for HEDIS 2011-2013.

Behavioral Health

Follow-up After Hospitalization for Mental Illness (FUH) –The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

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

> *Findings: For HEDIS 2011 all regions except the West were above the NCQA mean for both numerators. For HEDIS 2012 and 2013 all regions reported both numerators above the NCQA mean with the exception of both San Juan and the West.*

Follow-up Care for Children Prescribed ADHD Medication (ADD) – The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who have at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

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

> *Findings: The North and Southeast regions were above the NCQA mean for all three years for both numerators. All regions, with the exception of the West, were above the NCQA mean for HEDIS 2013 for the C&M Phase.*

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following:

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

> *Findings: The Northeast region reported rates above the NCQA mean for HEDIS 2011- 2013.*

Antidepressant Medication Management (AMM) – The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported:

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

Findings: All regions were above the NCQA mean for the three years with the exception of the West region and the San Juan region for both HEDIS 2012 and HEDIS 2013.

Identification of Alcohol and Other Drug Services (IAD) – This measure summarizes the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year.

- Any services
- Inpatient
- Intensive outpatient or partial hospitalization
- Outpatient or ED

Findings: All regions reported rates below the NCQA mean.

Mental Health Utilization (MPT) – The number and percentage of members receiving the following mental health services during the measurement year:

- Any services
- Inpatient
- Intensive outpatient or partial hospitalization
- Outpatient or ED

Findings: The MetroNorth region reported rates above the NCQA mean for any services and outpatient or ED for HEDIS 2011 - 2013. The East and Southeast also reported rates above the NCQA mean for any services and outpatient or ED for HEDIS 2012.

Validation of Performance Improvement Projects

This section of the report presents the results of IPRO's evaluation of the Medicaid Performance Improvement Projects (PIPs) submitted by Humana Health Plan, Medical Card System (MCS), and APS Healthcare for the contract period 2012-2013. The assessment was conducted using a tool developed by IPRO and consistent with CMS EQR protocols for PIP Validation.

APS Healthcare Medicaid Managed Behavioral Health Organization (MBHO) Performance Improvement Projects

The following narrative summarizes two (2) PIP proposals submitted by during the validation period.

PIP #1: Obesity and Depression

Study Topic Selection:

APS Healthcare described the PIP topic very broadly but with a very specific intervention. APS stated that the objective of this PIP was to evaluate the impact of "better management of the diagnosis of depression" on "the beneficiary's overall physical and mental well-being." APS defined "better management of the diagnosis of depression" as empowerment of the member to "manage his/her depression and diabetes" through education, telephonic follow-up, and compliance with medication and psychotherapy appointments. The project summary mentions the management of diabetes and depression, yet diabetes is never linked to the indicator, intervention or proposed outcomes.

The MCO cited several national statistics and study results regarding obesity, causes of obesity, and the association of obesity with mood disorders and depression as the study rationale. The rationale included evidence supporting the use of Cognitive Behavioral Therapy (CBT) as a psychotherapy model to treat depression. APS did not include evidence supporting the use of this treatment modality to address the special needs and challenges of patients with depression and obesity in particular. Additionally, based on the information provided, it is not clear how the intervention, CBT, impacts medication compliance, appointment attendance, and prevention of complications.

APS did not state how the topic was relevant specifically to the Medicaid population it serves and the resources available to implement and sustain this intervention for its affected population. Relevant information would include: prevalence of obesity and depression among the MCO's Medicaid population; behavioral health utilization data; examples of successful models that have used these methods for this population or a comparative group; information on the MCO's current performance on the treatment of obesity and depression; and barrier analysis of difficulties faced by affected members.

Study Question(s) and Indicator(s):

The study question was stated as: "How [does] the use of cognitive behavioral therapy in patients with depression and obesity improve depressive symptoms?" Although it is stated as a measureable outcome, the study question is vague in relation to the intended outcomes stated in the study topic.

The indicator for this PIP was stated as "Drop of > 5 points from baseline PHQ-9." Although the indicator measures improvement in depressive symptoms of the participants, the indicator does not measure the impact on resulting outcomes, such as APS's behavioral health utilization rates, member satisfaction, coordination of care, or any part of the system providing behavioral health care or primary care. The PHQ-9 score can only demonstrate depression severity to guide treatment and may not be an

appropriate indicator for a valid PIP, a quality improvement project that impacts the effectiveness of the care delivery or population health outcomes. An example of an appropriate measure would be to evaluate improvement in medication adherence among participants using the HEDIS® 2014 Antidepressant Medication Management (AMM) measure to track improvements in member compliance with antidepressants at 84 and 180 days.

The indicators should be clearly defined and measure the stated objectives. APS lists "Increase the number of patients with those conditions receiving mental health services" as one of the objectives. This cannot be measured by decreases in individual members' PHQ-9 score. APS should have included process and/or outcome measures to determine a discreet and quantitative improvement in the identification of members with obesity and depression and access/availability/referrals for care.

Study Population and Sampling:

The stated study population includes Medicaid members ages 18 years and older with a BMI greater than or equal to 30 and a PHQ-9 score greater than or equal to 10 and those referred by the MCO's disease management program. APS did not explain how BMI will be identified for the members in the eligible population or the specific criteria for MCO referral. APS used two data sources for population identification. The sources were APS claims data provided by the APS Reporting Area automated data systems and the MCO and TPA's referrals. The MCO does not describe which area/department within the MCO makes the referrals or the method of referrals. APS does not specify the type of disease or case management program in which the members were enrolled.

APS used two data sources for population identification. The sources were APS claims data provided by the APS Reporting Area automated data systems and disease management referrals. Eligible members are identified through claims for a major depressive disorder during the preceding six months.

Data Collection Procedures:

The study design is a pretest/posttest approach where the program psychologist administers the PHQ-9, conducts 8 biweekly telephone CBT sessions and re-measures the member's PHQ-9 score at the completion of the program. APS also planned to collect demographic information (e.g., age, gender and region) and track the number of opt-outs for the program. The baseline and measurement periods are not defined. The sample size is not described.

Although this may be adequate data to measure the impact of CBT on the depressive symptoms of the participating members, a more comprehensive PIP approach would monitor claims or encounter data for behavioral health utilization, pharmacy claims for medication adherence, and/or attendance rates for behavioral health appointments among the members in the treatment group.

Additionally, no data source or collection method is described for the BMI metric.

Interventions/Improvement Strategies:

APS describes its intervention as a patient self-care strategy through the provision of telephonic CBT, educational materials and follow-up. The MCO also notes coordination of services in order to improve access to preventive services and medication. No provider-focused strategies were listed. In addition, because the intervention is described in the area labeled "Date Implemented", no implementation dates were provided.

A more robust intervention strategy would have included system-targeted improvements, such as development of a program that:

- Identifies protocols for outreach and enrollment in case management and indications for referral to a CBT or behavioral health program;
- Initiates provider training on identification of depression among obese members;
- Ensures the availability of CBT certified providers in the plan's provider network; or
- Coordinates care and referrals between PCPs and behavioral health professionals.

Data Analysis and Results:

The PIP status report shows that as of June 2013, 38 members were enrolled in the program, 6 members were described as active, 13 members dropped out, and 13 members were discharged. Forty-six percent of those who dropped out chose to leave the program after the second session.

Indicator(s)	Baseline Score* (N=19)	Final Score* (N=18)	Target or Goal (5 points below baseline)	Target or Goal Met?
PHQ -9 mean scores	18	8	13	Yes**

*No date was provided for collection of baseline score or final score

**The target was met; however, it is unclear if the population used at baseline is the same as those included at the final measurement.

The stated number of participants in the program does not correspond with what is described in the status report. The total sample size of 38 patients does not match the sample size (37) on the data report printed from GraphPad Software. From the report, it is not possible to determine if the members who were discharged were those who opted out and/or completed the program. The number of sessions attended by the active participants is not described. It is also unclear if the participants tested at baseline were the same as those tested at the re-measurement.

Other results are presented for process measures, which were not described as indicators. The findings include: 16.4% of members received coordination of ambulatory services; 19.5% received educational materials; and 5.1% received homebound services. A description of the services provided and educational materials; the staff responsible for initiating and monitoring referrals; and the criteria for referrals was not described. Since these metrics were not included as indicators, there are no goals or targets given.

Achievement of Improvement:

APS stated there was a significant improvement in members' symptoms as indicated by the decline in PHQ-9 mean scores. However, the small sample size was not addressed and, as noted prior, it is unclear if the same population was scored at baseline and re-measurement. Other concerns that impact the validity of the PIP results are described above.

Achievement of Sustained Improvement:

No measurement for sustained improvement was provided. Additionally, it is not clear how the program will be sustained. APS did not discuss how the intervention was and will be staffed; who will continue to conduct CBT; or who will identify members with obesity and depression after the PIP is completed.

Strengths:

- The MCO chose a focus area that combines national health priorities.
- The MCO applied an evidence-based treatment intervention.
- The MCO used an evidence-based screening tool.

Opportunities for Improvement:

- The MCO should have included relevance to its membership and/or network facilities, e.g., behavioral health utilization rates, in the rationale for the study topic.
- Barrier analysis may have helped prove relevance to the member population.
- The MCO should have provided evidence and rationale for using telephonic versus face-to-face CBT, for example, that telephone contact would allow greater access and availability of services.
- The MCO should have specifically defined the indicators; how the indicators measure the stated objectives; and more closely aligned the indicators with a quality improvement strategy.
- The MCO should have included the process indicators within the methodology.
- The MCO should have considered sustainability during intervention development to ensure that continued improvement would occur after conclusion of the PIP.
- The MCO should have addressed the small sample size, especially since the rationale did not include relevance to the membership. If the sample size was small due to a low prevalence of the co-morbidities obesity and depression among members, then the topic may not have been relevant and a higher-risk area should have been chosen.
- The MCO should have stated the measurement periods.
- The MCO should have included staff roles and qualifications and outlined specific processes for coordination of services in the intervention description.
- The MCO should have incorporated an assessment of the needs of the population (barrier analysis) and multidisciplinary input in the intervention development.
- The MCO should have examined the interim measurements and assessed program difficulties and re-evaluated the effectiveness of the intervention and make modifications as needed.
- The MCO should have reported the data and results with accurate counts and calculations and collection dates for baseline and re-measurement period(s).
- The MCO should have explained the discrepancies in the number(s) of members, described a barrier analysis, and adjustments to the intervention strategy to improve member retention in the program.

Overall Credibility of Results

There are one or more validation findings that indicate a bias in the PIP results.

- The indicator was not clearly defined.
- The source of the BMI data used to identify the eligible population was not stated.
- The measurement periods were not stated.
- The small sample size was not addressed and it is unclear if the same population was scored at baseline and re-measurement.
- Results and data were not reported with accurate counts, calculations and collection dates for the baseline and re-measurement period(s).

PIP #2: Depression and Diabetes Wellbeing

Study Topic Selection:

APS Healthcare stated that the objective of this PIP was to evaluate the impact of "better management of the diagnosis of depression" on "the beneficiary's overall physical and mental well-being." The MCO defined the "better management of the diagnosis of depression" as empowerment of the member to "manage his/her depression" through telephonic Cognitive Behavioral Therapy (CBT).

The MCO cited several national and regional statistics and study results regarding diabetes, the risk of depression among those with diabetes, and the presence of diabetes and depression among Puerto Rico's top 15 health conditions as the study rationale. The rationale also included evidence supporting the benefit of a disease management program and the use of Cognitive Behavioral Therapy (CBT) as a psychotherapy model to treat depression.

APS mentions the use of a disease management program in the study topic description. The barriers or challenges to the existing disease management program are not clear or if CBT will be added to the current disease management program services. The existing disease management program, from which the study population was drawn, was not described. APS did not include evidence supporting the use of CBT to address the special needs and challenges of patients with depression and diabetes in particular.

APS did not state how the topic was relevant specifically to the Medicaid population it serves and the resources available to implement and sustain this intervention for its affected population. Relevant information would include: prevalence of diabetes and depression among the MCO's Medicaid population; behavioral health utilization data; examples of successful models that have used these methods for this population or a comparative group; information on the MCO's current performance on the treatment of diabetes and depression; and barrier analysis of difficulties faced by affected members.

Study Question(s) and Indicator(s):

The study question was stated as: "Do patients with diabetes and depression receiving Cognitive Behavioral Therapy in a Disease Management program improve their depressive symptomatology?" The question defines the population and a measureable outcome.

The indicator for this PIP was stated as "Drop of > 5 points from baseline PHQ-9." Although the indicator measures improvement in depressive symptoms of the participants, the indicator does not measure the impact on resulting outcomes such as the MCO's behavioral health utilization rates, member satisfaction, coordination of care, or any part of the system providing behavioral health care or primary care. The PHQ-9 score can only demonstrate depression severity to guide treatment and may not be an appropriate indicator for a valid PIP, a quality improvement project that impacts the effectiveness of the care delivery or population health outcomes. An example of an appropriate measure would be to evaluate improvement in medication adherence among participants using the HEDIS® 2014 Antidepressant Medication Management (AMM) measure to track improvements in member compliance with antidepressants at 84 and 180 days.

The indicator partially measures the stated objectives. APS lists "identification of the population with diabetes and depression" as one of the objectives. This cannot be measured by decreases in individual member's PHQ-9 score, but could be measured by the number of referrals for CBT from the Disease Management program. Decreasing depressive symptoms from baseline to post-CBT using PHQ-9 scores may be a reasonable indicator related to the study objectives. APS should have included process and/or

outcome measures that measure a discreet and quantitative improvement in the identification of members with diabetes and depression and access/availability/referrals for care.

Study Population and Sampling:
The stated study population includes Medicaid members ages 18 years and older with a diagnosis codes for a depressive disorder and diabetes and members in the disease management program with a PHQ-9 score greater than or equal to 10. APS does not specify the type of disease or case management program in which the members would be enrolled.

APS used two data sources for population identification. The sources were APS claims data provided by the APS Reporting Area automated data systems and disease management referrals. Eligible members are identified through claims for a major depressive disorder during the preceding six months.

Data Collection Procedures:
The study design is a pretest/posttest approach where the program psychologist administers the PHQ-9, conducts 8 biweekly telephone CBT sessions and re-measures the member's PHQ-9 score at the completion of the program. APS also planned to collect demographic information (e.g., age, gender and region) and track the number of opt-outs for the program. The baseline and measurement periods are not defined. The sample size is not described.

Although this may be adequate data to measure the impact of CBT on the depressive symptoms of the participating members, a more comprehensive PIP approach would monitor claims or encounter data for behavioral health utilization, pharmacy claims for medication adherence, and/or attendance rates for behavioral health appointments among the members in the treatment group.

Interventions/Improvement Strategies:
APS describes its intervention as a patient self-care strategy through the provision of telephonic CBT, educational materials and follow-up. The MCO also notes coordination of services in order to improve access to preventive services and medication. No provider-focused strategies are listed. No implementation dates were provided for the interventions. No provider-focused strategies were listed.

A more robust intervention strategy would have included system-targeted improvements, such as development of a program that:

- Identifies protocols for outreach and enrollment in case management and indications for referral to a CBT or behavioral health program;
- Initiates provider training on identification of depression among members with diabetes;
- Ensures the availability of CBT certified providers in the plan's provider network; or
- Coordinates care and referrals between PCPs and behavioral health professionals.

Data Analysis and Results:
No results were provided.

Achievement of Improvement:
No discussion of improvement achieved was provided.

Achievement of Sustained Improvement:
No data for sustained improvement was provided.

Strengths:

- The MCO chose a focus area that combines national health priorities.
- The MCO applied an evidence-based treatment intervention.
- The MCO used an evidence-based screening tool.

Opportunities for Improvement:

- The MCO should have included relevance to its membership and/or network facilities, e.g., behavioral health utilization rates, in the rationale for the study topic.
- Barrier analysis may have helped prove relevance to the member population.
- The MCO should have provided evidence and rationale for using telephonic versus face-to-face CBT, for example, that telephone contact would allow greater access and availability of services.
- The MCO should have specifically defined the indicators; how the indicators measure the stated objectives; and more closely aligned the indicators with a quality improvement strategy.
- The MCO should have considered sustainability during intervention development to ensure that continued improvement would occur after conclusion of the PIP.
- The MCO should have included the sample size and the method used to determine a valid sample size.
- The MCO should have considered an over-sample in anticipation of disenrollment and program opt-outs.
- The MCO should have stated the measurement periods.
- The MCO should have included staff roles and qualifications and outlined specific processes for coordination of services in the intervention description.
- The MCO should have incorporated an assessment of the needs of the population (barrier analysis) and multidisciplinary input in the intervention development.

Overall Credibility of Results

The credibility of the PIP results cannot be determined since no results were provided.

Humana Health Plan of Puerto Rico Medicaid Managed Care Performance Improvement Project(s)

The following narrative summarizes the PIP submitted by Humana Health Plan of Puerto Rico, and IPRO's validation results.

PIP #1: Impact of an initiative for early identification of Chronic Kidney Disease (CKD) in members with Diabetes Mellitus.

Following is a summary of the PIP conducted by Humana Health Plans of Puerto Rico, Inc. to address this topic.

Study Topic Selection:
Humana provided a strong rationale for its study topic selection. Diabetes is a health issue that affects a large population nationwide and within the Plan's membership. Diabetics have a high risk for developing CKD. The rationale included MCO-specific and national statistics including the following:

- Ten percent of HHP's diabetic members were diagnosed with CKD (2011).
- Diabetes was the 7th leading cause of death in the U.S. (2007).
- 25.8 million people in the U.S. have diabetes; only 18.8 million diagnosed (2011).
- Diabetes was the leading cause of kidney failure, 44% of all new cases (2008).
- ARB/ACE medications helped to reduce proteinuria (a risk factor for developing kidney disease) by 35%. (National Diabetes Fact Sheet, 2011).
- Annual CKD screening is recommended for patients at risk of CKD.
- The KDOQI and ADA guidelines recommend screening for microalbuminuria in all patients at risk for kidney disease.

Study Question(s) and Indicator(s):
The study question was clearly stated: "Do specific educational interventions have an impact on the early identification of Chronic Kidney Disease (CKD)?" The indicators chosen were Creatinine testing, Microalbumin screening and use of ACE/ARB's.

Study Population and Sampling:
The study population was well-defined as HHP's Medicaid members 18-75 years of age with diabetes (type 1 and type 2) from the East, Southeast and Southwest regions. HEDIS® Technical Specifications were used to select the eligible population, excluding the continuous enrollment requirement. No sampling was used.
The numerator events were defined:

- Creatinine testing - '82553','82554','82565','80047','80048','80053','80069'
- Microalbumin testing- '82042','82043','82044','84156'
- Use of ACE/ARB's – HEDIS® Technical specifications Comprehensive Diabetes Care measure. Table CDC-L/Table DCDC-P: ACE Inhibitors/ARBs

Data Collection Procedures:
Data was collected for each measure by the Humana Health Economics (HCE) Department using administrative medical and pharmacy claims during the measurement period. Data was collected for the

baseline year 2011-2012 (pre-intervention) and the re-measurement year 2012-2013 (post-intervention), resulting in two measurement periods – a baseline and one (1) re-measurement.

Interventions/Improvement Strategies:

Provider-focused interventions:
Developed provider-focused education to improve the effectiveness of identifying members with CKD. (Note: The report does provide the percentage of all eligible Providers impacted by region).

- Distributed a Diabetes Management Guidelines CD to 728 PCPs during the 3rd quarter 2012 and 1st quarter 2013.
- Sent Humana newsletters to 100% of all PCPs and specialists:
    - April 2012: Diabetic Neuropathy - sent in the baseline year
    - March 2013: Hypertension - distributed late in the 3rd quarter of the re-measurement year. This may have been too late in the project life cycle to have an appreciable impact on outcomes.
    - July 2013: Correct Use of Medications - distributed after completion of the re-measurement. Therefore, it had no impact on the PIP outcome.
- Implemented monthly Academic Detailing visits to 443 providers by licensed pharmacists to provide unbiased, non-commercial, evidenced-based information with the goal of improving the quality of care.
- Distributed quarterly gap reports identifying members in need of creatinine screening, microalbumin screening and/or ACE/ARB inhibitor prescription to PCPs via the provider web portal.
- Held educational seminars "Living with the enemy: Diabetes Mellitus" given by the Humana Medical Director and an Endocrinologist. Attended by 60 PCPs in April 2013. Held late in the re-measurement period and may have been too late to have an appreciable impact on outcomes.

Identified possible provider barriers including: unwillingness to prescribe medications due to side effects and member concerns about side effects. This barrier was mitigated by the Academic Detailing program which utilized licensed pharmacists to meet with providers and focus on medication education. The provider-focused interventions addressed education on medication & CKD that providers could use to address these barriers with members.

Member-focused interventions:

- No member-focused interventions were implemented for this PIP.

Health Plan-focused intervention(s):

- No health plan-focused interventions were implemented for this PIP.

Additionally, the following intervention was planned going forward:

- Introduce a new measure to evaluate the timeliness of referrals to nephrologists.

Data Analysis and Results:
Data were collected using administrative medical and pharmacy claims in the baseline and re-measurement year. The following were tracked:

- The number of eligible members with diabetes who had a creatinine screening test completed during the measurement period.

- The number of eligible members with diabetes who had a microalbumin screening test completed during the measurement period[2].
- The number of members with diabetes who were prescribed at least one ACE/ARB medication during the measurement period.

The indicator results from the baseline year (2011-2012) & re-measurement year (2011-2013) were as follows:

- Creatinine testing increased by an average of 40.63 percentage points for all 3 regions. East increased 36.2 percentage points (22.8% to 59%); Southeast increased 44.2 percentage points (16.8% to 61%); Southwest increased 41.5 percentage points (18.5% to 60%).
- Microalbumin screening increased by an average of 8.97 percentage points for all 3 regions. East by increased 11.2 percentage points (22.8% to 34%); Southeast increased 10.2 percentage points (16.8% to 27%); Southwest increased 5.5 percentage points (18.5% to 24%).
- ACE/ARB medication usage remained relatively flat but increased by an average increase of 0.7 percentage points for all 3 regions. However, the Southeast and Southwest regions saw a decline of 1.2 percentage points and 5.4 percentage points respectively. East increased 8.7 percentage points (50.3% to 59%); Southeast decreased 1.2 percentage points (54.2% to 53%); Southwest decreased 5.4 percentage points (65.4% to 60%).[3]
- None of the indicators reached the target identified in the PIP.[4]

Over the course of the study, the creatinine testing and microalbumin screening indicators showed improvement compared to the baseline year. However, use of ACE/ARB's remained relatively flat with an average increase of 0.7 percentage points for all 3 regions. It is reasonable to state that, other things being equal, the interventions had a positive effect on the indicator results except for the decline in ACE/ARB usage in the Southeast & Southwest regions. The same data collection techniques were used for all 3 regions so this would not have been factor in the decline in ACE/ARB usage in the Southeast and Southwest regions. The decline in these two regions could be attributed to the identified barriers and lack of uniformity & timeliness of the implementation of the interventions for providers across all regions. However, the effectiveness of outreach & education for the providers was not tracked in a quantifiable manner so these conclusions cannot be made with any certainty.

[2] Note: The numerator description says "creatinine test" where it should say "microalbumin screening".
[3] Note: The data in the PIP results table reported the same exact baseline data section for ACE/ARB use as reported in the Creatinine testing data section the Southeast and Southwest region. The Plan should verify that the actual results for ACE/ARB use are accurate. It is possible that the base year data for Creatinine testing were entered in these fields in error.
[4] Note: The PIP reported a goal rate of 75% for ACE/ARB use but the data table in the PIP for measurement year 2012-2013 shows a goal rate of 68.13%. The Plan should verify that the goal rate in the measurement year is 75% as it was in the baseline year.

Humana Health Plans of Puerto Rico, Inc. PIP 2012-2013 Impact of an initiative for early identification of Chronic Kidney Disease in members with Diabetes Mellitus.					
Indicator(s)	**Baseline Rate 2011-12 by region**	**Interim Rate**	**Final Rate 2012-13 by region**	**Target or Goal**	**Target or Goal Met?**
% members that completed a Creatinine testing	East 22.8% SE 16.8% SW 18.5%	NA	East 59% SE 61% SW 60%	68.13%	No
% members that completed a Microalbumin screening	East 22.8% SE 16.8% SW 18.5%	NA	East 34% SE 27% SW 24%	68.13%	No
% use of ACE/ARB medications	East 50.3% SE 54.2% SW 65.4%	NA	East 59% SE 53% SW 60%	75.00%	No

Achievement of Improvement:

- Creatinine testing improvement ranged from 36.2 to 44.2 percentage points from baseline for all 3 regions.
- Microalbumin screening improvement ranged from 5.5 to 11.2 percentage points from baseline for all 3 regions.
- ACE/ARB medication usage ranged from a decrease of 5.4 percentage points to an increase of 8.7 percentage points from baseline for all 3 regions.

Achievement of Sustained Improvement:

The PIP study only contained 1 re-measurement year (2012-2013) for comparison to the baseline year (2011-2012). Therefore, it is not possible to determine if there has been sustained improvement due to a lack of multiple year data for evaluation.

Overall Credibility of Results

The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution because indicator improvements attributed to the interventions is uncertain as results were not reported separately for indicators or for the effectiveness of Provider education interventions. There are discrepancies in reported data results and goal rates and there is a lack of a clear description of methodology of determining the indicator rates for the measures used to determine the early detection of CKD.

Strengths:

- Humana selected a topic relevant to its membership which could result in improved screening for the early identification of CKD & preventive care for diabetic members with CKD. This could lead to potentially decreased costs, increased prevention\control of complications related to

diabetes, increasing diabetic member's life expectancy and improvements in member's overall health & satisfaction.

- The plan cited evidenced-based sources for topic rationale and provider interventions.
- The interventions lead to improved CKD indicators results in all regions and increased ACE/ARB use in 1 out of 3 regions. The increased frequency of CKD testing impacted a greater number of diabetic members and the screening exams are effective tools for early identification and\or prevention of CKD.
- The PIP's education-focused interventions encourage Providers to be more proactive to screen diabetic members for early identification of CKD.
- The PIP study population is inclusive of all diabetic members which allows for a great accuracy of results and improved early identification of CKD.

Opportunities for Improvement:

- There was an opportunity for the Plan to integrate member-focused interventions directed towards diabetic members emphasizing medication education & disease control\prevention. This could be accomplished in conjunction with care coordination through Case Management & Disease Management type programs to produce a positive effect on member outcomes.
- The PIP identified a barrier of member and Provider concerns about medication side effects. Efforts to provide focused medication related education to members and Providers could lead to increased utilization of these medications to prevent and\or slow the progression of CKD.
- The Plan should report and track the project's identified process measures to evaluate reach and effectiveness of Provider education interventions with the goal of impacting 100% of all Providers across all regions. There is an opportunity for increased effectiveness in early detection of CKD if future interventions are directed towards 100% of all eligible Providers and provided in a timely manner within the interventions to maximize outcomes.
- There are reporting errors in the data table presented in the PIP. Improved accuracy of reporting results provides the Plan the opportunity to present results accurately and not subjecting them to interpretation.
- The PIP should define the methodology for calculation of rates for the indicator numerators & denominators defined in the PIP.

PIP #2: Controlling High Blood Pressure

Following is a summary of the PIP conducted by Humana Health Plans of Puerto Rico, Inc. to address this topic.

Study Topic Selection:

Humana provided a strong rationale for its study topic selection. Hypertension is a health issue that affects a large population nationally and within the MCO's membership. Members with poorly controlled blood pressure are at high risk for developing significant co-morbid conditions & complications. The study rationale refers to regional\national statistics, but not MCO-specific statistics, nor does it cite sources for every reported statistic. Humana provided the following in the rationale:

- Lifestyle factors increase the risk of hypertension: diabetes, diet, weight, physical inactivity and alcohol abuse.
- Related complications: heart attack, stroke, aneurysm, heart failure, renal disease and metabolic syndrome.
- The CDC reports the 2009-2010 adjusted prevalence of hypertension among adults aged 18 years and over at 28.6%.
- Only 47% of people with high blood pressure have their condition under control.
- National costs of high blood pressure are $47.5 billion annually.
- Hypertension is the most prevalent chronic condition in Puerto Rico affecting 27.3% of residents.
- During 2011 Chronic Kidney Disease was prevalent in 10% of Humana's diabetic population.

Study Question(s) and Indicator(s):

Humana's PIP study question was clearly stated: "Do specific educational interventions have an impact on the control of high blood pressure?"

The PIP indicator during the baseline year (2010) and re-measurement years (2011-2013): HEDIS® Controlling High Blood Pressure (CBP).

- Numerator - Total members 18-85 years of age who had a diagnosis of hypertension and BP was adequately controlled (<140/90) during the measurement year.
- Denominator - Medicaid members 18- 85 years of age from East, Southeast (SE) and Southwest (SW) regions with diagnosis of hypertension.

HEDIS® Technical Specifications were used to select the eligible population, collect the data, and calculate the rate.

The measurement periods were stated as 2011, 2012 and 2013, though the PIP time frame was listed as 7/1/2011 to 6/30/2013. This may have been because HEDIS® data were used and results are available in June annually.

Study Population and Sampling:

The eligible population was comprised of Medicaid members ages 18-85 years from the East, SE and SW regions with a diagnosis of hypertension. HEDIS® Technical Specifications were used to select population. Members ages18–85 years with a claim with a ICD-9-CM diagnosis code 401 and who had at least one outpatient encounter with a **diagnosis of hypertension during the first six months** of the measurement

year. Exclusions included evidence of ESRD or pregnancy and\or the member had an admission to a non-acute inpatient setting during the measurement year.

Sampling was conducted according to the HEDIS® Technical Specifications for the CBP measure. A sample of 411 cases was selected from the eligible population.

Data Collection Procedures:

Data were collected via medical record review (hybrid methodology) according to HEDIS® Technical Specifications. The PIP report does not describe the number of staff used to collect the data, their qualifications or the data collection tool. The data collection was done per HEDIS® specifications. Humana's HEDIS® data collection was audited for at least two of the measurement periods. The same methodology was employed for all measurement periods.

Interventions/Improvement Strategies:

Provider-focused interventions:

Humana developed provider-focused education programs to improve control of high blood pressure. Humana reported the percentage of eligible providers impacted in total and by region. The report also states that educational seminars were attended by a total of 180 providers; however, the number per year was not given.

First year intervention(s):

- Distributed Hypertension Management Guidelines (all eligible providers) - completed 3rd quarter 2011 and ongoing for new providers.
- Conducted monthly Academic Detailing visits using licensed pharmacists to provide unbiased, non-commercial, evidenced-based information about medications, clinical guidelines and HEDIS® measures related to hypertension (443 Providers) - completed..
- Distributed quarterly gap reports identifying members with hypertension to PCPs via the provider web portal (100% of PCPs) – completed.
- Held focused educational seminars for PCPs: Management of Hypertension, CAD and its Association with Stress - completed 4th quarter 2011.

Second year intervention(s):

- Held focused educational seminars for PCPs: Nutrition, Obesity and Stress (180 providers) - completed 4th quarter 2011.

Third year intervention(s):

- Held focused educational seminars for PCP's: The Good, the Bad and My Heart: Hypertension and Cardiovascular Conditions - completed 2nd quarter 2013.
- Distributed educational information to PCPs through Humana's provider newsletters (100% PCPs & specialists) – completed 1st, 2nd, and 3rd quarters 2013. Two of the newsletters were distributed late in measurement year 3; one of which was distributed after the PIP ended.

Member-focused interventions:

No member-focused interventions were implemented for this PIP.

Health Plan-focused Interventions:

No health plan-focused interventions were implemented for this PIP.

The following was planned going forward:

Continue to implement current and new initiatives targeting control of high blood pressure. Evaluate possible causes for lack of improvement in the East region. The specific initiatives or the method(s) to evaluate the lack of improvement in the East region were not described.

Barriers identified:

- Provider barriers were very general and included: knowledge, awareness and motivation. Specific barriers and root causes were not identified (e.g., what were the knowledge/awareness deficit(s), what motivation was lacking and why). These barriers were mitigated for some providers through the Academic Detailing program.
- Member barriers included: attitudes towards hypertension, concerns about medication side effects, lack of medication adherence and reluctance to initiate lifestyle changes or drug treatment. A plan to mitigate these barriers was not described. However, the provider-focused interventions addressed medication & hypertension education and may have been used by providers to educate members.

Data Analysis and Results:

The same specifications, sampling and data collection methods were used using at baseline and all re-measurement periods.

The rate declined in the East region by 1.22 percentage points while the SE and SW regions increased by 13.62 and 20.21 percentage points respectively (comparing the baseline to final the re-measurement results). None of the regions achieved the target rate of 63.33% during any of the measurement periods.

The rates for the SE and SW regions consistently improved across the 3 re-measurement periods. It is reasonable to state that, other things being equal, the interventions had a positive impact. The rates for the East region initially improved in re-measurement year #1, declined but remained above baseline in re-measurement year #2, then fell below baseline in year #3.

The same specifications, sampling, and data collection methodology were used for all 3 regions; therefore, this could not have been a factor for the poorer performance in the East region. Lack of uniformity & timeliness in implementing the interventions across providers and regions may have been a factor. However, this cannot be concluded because the effectiveness and timing of the provider outreach & education was not tracked.

Humana Health Plans of Puerto Rico, Inc. PIP 2011-2013 Controlling High Blood Pressure Rates by Region						
Indicator(s)	**Baseline Rate HEDIS 2011**	**Interim Rate 2011**	**Interim Rate HEDIS 2012**	**Final Rate HEDIS 2013**	**Target or Goal**	**Target or Goal Met?**
% members with blood pressure controlled (< 140/90)	East 43.31%	East 47.20%	East 44.53%	East 42.09%	63.33% all regions	No
	SE 40.39%	SE 45.26%	SE 49.64%	SE 54.01%		No
	SW 35.50%	SW 45.74%	SW 45.99%	SW 55.71%		No

Achievement of Improvement:

As described above, the rate for the East region improved (compared to baseline) in both re-measurement years #1 and #2. The re-measurement year #1 rate was above the HEDIS® national average of 47%, while the rate for year #2 was below. The East region did not achieve the target rate of 63.33% in periods #1 or #2.

The SE and SW regions' rates improved (compared to baseline) in both re-measurement years #1 and #2. For the SE region, the rate at re-measurement period #2 was above the HEDIS® national average (47%). For the SW region the rates for both re-measurement periods #1 and #2 exceeded the national mean. Neither the SE or SW regions achieved the target rate of 63.33% periods #1 or #2.

Achievement of Sustained Improvement:

The rate for the East region declined in re-measurement year #3 (compared to baseline). Re-measurement year #3's rate fell below the national average. The East region never achieved the target rate of 63.33%.

The SE and SW regions' rates improved (compared to baseline) in all three re-measurement years. For the SE region, the rate at re-measurement period #3 was above the HEDIS® national average (47%) as did the rate for the SW region. Neither the SE or SW regions achieved the target rate of 63.33% in any measurement period.

The East region rates improved but then declined and the SE and SW regions showed consistent improvement across the 3 re-measurement periods. The SE and SW regions' baseline rates were lower than the East region (SE 40.39%, SW 35.50%, and East 43.31%) but both regions showed greater overall improvement compared to the East region.

Overall Credibility of Results

There were no validation findings to indicate that the credibility of the PIP results is at risk.

Strengths:

- Humana selected a topic relevant to its membership and for which evidence-based interventions could result in substantial improvement of control of high blood pressure which could lead to potentially decreased costs, increased prevention\control of hypertension and its related complications, improvement in members' overall health and member satisfaction.
- The interventions led to sustained improved control of high blood pressure indicators for members in 2 of the 3 regions impacted by the PIP.

- The provider education interventions were proactive and appeared to have a positive effect on the rates for controlling high blood pressure.

Opportunities for Improvement:

- The MCO should report and track process measures to evaluate the reach and effectiveness of the provider education interventions. The MCO should strive to reach 100% of providers across all the regions. This may help to identify the reason that improvement was not achieved for all regions.
- Humana should explain why some of the educational newsletter articles were provided late or after the PIP concluded, since this minimized the potential impact on improvement.
- The MCO should conduct a barrier analysis to identify and confirm the root causes of the provider barriers "knowledge, awareness and motivation" and develop interventions to address the barriers.
- Humana should implement member-focused interventions to address the member barriers: attitudes towards hypertension and medications and reluctance to lifestyle changes. Interventions might include: member education programs and Case/Disease Management.
- The MCO should provide the source for target of 63.33% of eligible members with blood pressure controlled, e.g., Quality Compass®/HEDIS® mean or 75th percentile.

Triple S Medicaid Managed Care
Performance Improvement Project(s)

The following narrative summarizes the PIP submitted by Triple S, and IPRO's validation results.

PIP #1: Appropriate Medication Treatment for Asthmatics

Study Topic Selection:
No discussion with evidence-based rationale was provided by the Plan.

Study Question(s) and Indicator(s)
No relevant information was provided by the Plan other than a table of monthly data for the following indicators:

- "Appropriate use of asthma medication rate"

Study Population and Sampling:
Insufficient information was provided by the Plan to ascertain study population and sampling methodology.

Data Collection Procedures:
Insufficient information was provided by the Plan to ascertain data collection procedures. The table provided appears to be based upon claims data.

Interventions/Improvement Strategies:
Insufficient information was provided by the Plan to ascertain interventions/improvement strategies. Although the indicators presented in the table of monthly data (referenced above) appear to be HEDIS indicators, HEDIS was not specified as the method of measurement, and no numerators or denominators were specified. No process measures were included.

Data Analysis and Results:
The reported results are presented in the table below.

Appropriate Medication Treatment for Asthmatics					
Indicator(s)	**Baseline Rate* 7/27/2009–9/10/2009**	**Interim June 2013**	**Final Y2 - 2014**	**Project Success (Plan header)**	**Target or Goal Met?**
Appropriate use of asthma Medication Rate	13 (%?)	11 (%?)	Not reported	Increase 3% by June 2013	Unable to ascertain

Reported results were reported for June 2012, September 2012, December 2012, March 2013, and June 2013, with a final percentage change between June 2012 and June 2013, as follows:

Achievement of Improvement:

- The comparison of rates (or numerators) for the month of June 2012 to the month of June 2013 is not an appropriate comparison from which to gauge achievement of improvement. Rates should be reported for full year time periods, and should be calculated by dividing the numerator (event) by the denominator (eligible population). The data provided in the table is not clear whether numerator counts or percentage rates are provided. Project target or goal needs to be clearly stated

Achievement of Sustained Improvement:

- Insufficient information was provided by the Plan to ascertain sustained improvement.

Strengths:

- Insufficient information was provided by the Plan to ascertain study strengths.

Opportunities for Improvement:

- Insufficient information was provided by the Plan to identify specific opportunities for improvement.
- Numerators and denominator need to be clearly stated.

Insufficient information was provided by the Plan to conduct validation and generate external quality review findings

PIP #2: Cholesterol Screening and Control (of Blood Pressure) in Hypertensive Patients

Study Topic Selection:
No discussion with evidence-based rationale was provided by the Plan.

Study Question(s) and Indicator(s)
No relevant information was provided by the Plan other than a table of monthly data for the following indicators:

- "LDL-C tests perform rate"
- "Control of Blood Pressure rate"

Study Population and Sampling:
Insufficient information was provided by the Plan to ascertain study population and sampling methodology.

Data Collection Procedures:
Insufficient information was provided by the Plan to ascertain data collection procedures. The table provided appears to be based upon claims data.

Interventions/Improvement Strategies:
Insufficient information was provided by the Plan to ascertain interventions/improvement strategies. Although the indicators presented in the table of monthly data (referenced above) appear to be HEDIS indicators, HEDIS was not specified as the method of measurement, and no numerators or denominators were specified. No process measures were included.

Data Analysis and Results:
The reported results are presented in the table below.

Cholesterol Screening and Control (of Blood Pressure) in Hypertensive Patients					
Indicator(s)	**Baseline Rate* 7/27/2009–9/10/2009**	**Interim June 2013**	**Final Y2 - 2014**	**Project Success (Plan header)**	**Target or Goal Met?**
LDL-C Tests Perform Rate	11 (%?)	11 (%?)	Not reported	Increase 3% by June 2013	Unable to ascertain
Control of Blood Pressure Rate	8 (%?)	4 (%?)	Not reported	Increase 3% by June 2013	Unable to ascertain

Reported results were reported for June 2012, September 2012, December 2012, March 2013, and June 2013, with a final percentage change between June 2012 and June 2013, as follows:

Achievement of Improvement:

- The comparison of rates (or numerators) for the month of June 2012 to the month of June 2013 is not an appropriate comparison from which to gauge achievement of improvement. Rates

should be reported for full year time periods, and should be calculated by dividing the numerator (event) by the denominator (eligible population). The data provided in the table is not clear whether numerator counts or percentage rates are provided. Project target or goal needs to be clearly stated

Achievement of Sustained Improvement:

- Insufficient information was provided by the Plan to ascertain sustained improvement.

Strengths:

- Insufficient information was provided by the Plan to ascertain study strengths.

Opportunities for Improvement:

- Insufficient information was provided by the Plan to identify specific opportunities for improvement.
- Numerators and denominator need to be clearly stated.

Insufficient information was provided by the Plan to conduct validation and generate external quality review findings

PIP #3: Screening for Diabetics – HbA1c Testing and Eye Exams

Study Topic Selection:
No discussion with evidence-based rationale was provided by the Plan.

Study Question(s) and Indicator(s)
No relevant information was provided by the Plan other than a table of monthly data for the following indicators:

- "CDC-Eye exam performed rate"

Study Population and Sampling:
Insufficient information was provided by the Plan to ascertain study population and sampling methodology.

Data Collection Procedures:
Insufficient information was provided by the Plan to ascertain data collection procedures. The table provided appears to be based upon claims data.

Interventions/Improvement Strategies:
Insufficient information was provided by the Plan to ascertain interventions/improvement strategies. Although the indicators presented in the table of monthly data (referenced above) appear to be HEDIS indicators, HEDIS was not specified as the method of measurement, and no numerators or denominators were specified. No process measures were included.

Data Analysis and Results:
The reported results are presented in the table below.

Screening for Diabetics – HbA1c Testing and Eye Exams– Reported Results					
Indicator(s)	**Baseline Rate* 7/27/2009–9/10/2009**	**Interim June 2013**	**Final Y2 - 2014**	**Project Success (Plan header)**	**Target or Goal Met?**
CDC-HbA1c tests rate	142 (not clear whether this reflects a numerator and, if so, what the denominator, and thus, the rate is)	158 (same concern as in previous column)	Not reported	Increase 3% by June 2013	Unable to ascertain
CDC-Eye exam performed rate	42	55	Not reported	Increase 3% by June 2013	Unable to ascertain

Reported results were reported for June 2012, September 2012, December 2012, March 2013, and June 2013, with a final percentage change between June 2012 and June 2013, as follows:

Achievement of Improvement:

- The comparison of rates (or numerators) for the month of June 2012 to the month of June 2013 is not an appropriate comparison from which to gauge achievement of improvement. Rates should be reported for full year time periods, and should be calculated by dividing the numerator (event) by the denominator (eligible population). The data provided in the table is not clear whether numerator counts or percentage rates are provided. Project target or goal needs to be clearly stated

Achievement of Sustained Improvement:

- Insufficient information was provided by the Plan to ascertain sustained improvement.

Strengths:

- Insufficient information was provided by the Plan to ascertain study strengths.

Opportunities for Improvement:

- Insufficient information was provided by the Plan to identify specific opportunities for improvement.
- Numerators and denominator need to be clearly stated.

Insufficient information was provided by the Plan to conduct validation and generate external quality review findings

5. REVIEW OF MEDICARE INFORMATON

Background

The 42 CFR 438.360 establishes that to avoid duplication, the State may use, in place of a Medicaid review by its EQRO, information about the MCO/PIHPs obtained from a Medicare accreditation review to provide information otherwise obtained from the mandatory activities specified in §438.358 for the conduct of PIP and calculation of PMs if: (1)the MCO/PIHP serves only individuals who received both Medicare and Medicaid benefits, (2)the Medicare review activities are substantially comparable to the State-specified mandatory activities in §438.358(b), and (3)the MCO/PIHP provides to the State all the reports, findings, and other results of the Medicare review and the State provides the information to the EQRO.

PRHIA Requirements for MAOs

For the MCO contract period 2012-2013 EQR evaluation, the PRHIA required all Medicare Advantage Organizations (MAOs) participating in the Puerto Rico's Medicare Program to submit the following Medicare information as part of their mandatory EQR activities:

Validation of PIPs: 2012-2012 Quality Improvement Project (QIP)
Validation of PMs: HEDIS 2013 Healthcare Effectiveness Data and Information Set (HEDIS)

Objectives for Review of Medicare Information

For this activity, IPRO reviewed the Medicare information received from the PRHIA for each MAO and presented the findings in this chapter.

Assessment Tool for Review of Medicare Information

No specific tool was developed by IPRO for this activity since the results were presented as received; no validation process was done.

Methods for Data Collection and Analysis

Each MAO was required to submit their documentation directly to the PRHIA who then forwarded the information to IPRO.

Compliance Monitoring

For 2012-2013 EQR Evaluation, IPRO reviewed each of the Puerto Rico's MAOs participating in the Platino program to assess their compliance regulatory standards and contract requirements.

Compliance Monitoring

This section of the report presents the results of the reviews by IPRO of Puerto Rico Platino MCOs' compliance with regulatory standards and contract requirements for contract year 2012 - 2013. The information is derived from IPRO's conduct of the annual compliance reviews in December 2013 and January 2014. Requirements contained within CFR 42 Subparts C: Enrollee Rights, D: Quality Assessment and Performance Improvement, and F: Grievance System was reviewed.

A description of the content evaluated under each domain follows:

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

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

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

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

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

File reviews were conducted for the following:

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

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

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

- QAPI: Access - Care Management File Review: Files were assessed for the following:

    - Collaborative development of the case management plan.
    - Assessment of member needs.
    - Identification of goals and interventions.
    - Monitoring of progress.

American Health Medicare (AHM) 2013 Medicare Compliance Review Findings for Contract Year 2012-2013

A summary of the Medicare compliance results for AHM is provided below. For each standard, the following is provided: current year overall category compliance designations; a description of the current year findings for all standards/elements not found fully compliant including a summary of the file review results, and HHP's response and action plan as applicable. Assessment of the effectiveness of the plan's progress for elements not fully compliant in the prior review follows the 2013 findings.

AHM: Summary of 2013 Medicare Managed Care Compliance Review Findings (Review Year 2012/2013)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	49	44	3	2	0
Enrollee Rights and Protections	50	40	7	3	0
Quality Assessment and Performance Improvement (QAPI) – Access	48	45	1	2	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	23	19	2	2	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	32	16	11	5	0

AHM: Summary of 2013 Medicare Managed Care Compliance Review Findings (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
Grievance System	▪ Ensure that the individuals who make decisions on grievances and appeals are individuals – ➢ Who were not involved in any previous level of review or decision making; and ➢ Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease ➢ An appeal of a denial that is based on lack of medical necessity. ➢ A grievance regarding denial of expedited resolution of an appeal. ➢ A grievance or appeal that involves clinical issues.. Substantial Compliance: Policy does not addresses that reviewers should be those who were not involved in any previous level of review or decision making ▪ Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. Minimal Compliance: see file review ▪ Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process. Minimal Compliance: see file review. ▪ Include, as parties to the appeal – The enrollee and his or her representative; or the legal representative of a deceased enrollee's estate. Substantial Compliance: see file review. ▪ The MCO or PIHP must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal. Substantial Compliance: not provided in policies. <u>Appeal File Review</u> 20 files were reviewed. Of the 16 files that contained acknowledgment letters, each of the 16 informed members of the right to present evidence in writing, but not the right to present evidence in person. Therefore, none of the files was fully compliant with this requirement. 16 files that contained acknowledgment letters, none of the 16 acknowledgement letters contained the member's opportunity to examine the case file, including medical records, and any other documents and records considered before and during the appeals process. 1 of 20 involved an appeal filed by the member's provider, and 1 of 20 involved an appeal filed by the member's representative, but the file did not contain an AOR form. No files involved a representative of a deceased enrollee's estate.
Enrollee Rights and Protections	▪ MCO makes a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice. Substantial Compliance: policy not signed or

AHM: Summary of 2013 Medicare Managed Care Compliance Review Findings (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	dated. Effective date is Jan 1, 2006.. ▪ The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must provide the following information to all enrollees: The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers. Substantial Compliance: ASES phone number is in ANOC but language does not state how to contact the DOH for these services. ▪ How and where to access any benefits that are available under the State plan but are not covered under the contract. Substantial Compliance: ASES phone number is in ANOC but language does not state how to contact the DOH for these services. ▪ MCO must provide the following information to all enrollees: (i) names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. Minimal Compliance: No documentation or policies provided to substantiate requirement. ▪ MCO must provide any restrictions on the enrollee's freedom of choice among network providers. Substantial Compliance: Provider Directory shows the only limitations could be if the provider is not accepting new patients; this information not readily available to members. ▪ The extent to which, and how, after-hours and emergency coverage are provided, including: ▪ What constitutes emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in §438.114(a). ▪ The fact that prior authorization is not required for emergency services. ▪ The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent. ▪ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract. ▪ The fact that, subject to the provisions of this section, the enrollee has the right to use any hospital or other setting for emergency care. Substantial Compliance: After hours coverage not addressed. ▪ MCO must provide: Additional information that is available upon request, including the following: ▪ Information on the structure and operation of the MCO or PIHP. ▪ Physician incentive plans. Substantial Compliance. Not addressed in member handbook. ▪ Each enrollee must be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. Substantial Compliance. Not explicitly covered in documentation.

AHM: Summary of 2013 Medicare Managed Care Compliance Review Findings (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	▪ If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they may be amended or corrected, as specified in 45 CFR § 164.524 and 164.526. Minimal Compliance: Policy does not include wording related to correcting or amending the medical records. ▪ Each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, or PCCM and its providers or the State agency treat the enrollee. Minimal Compliance: not addressed in EOC or provider manual. ▪ MCO… complies with any other applicable Federal or State laws (such as Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality. Substantial Compliance: Not found in policy. Addressed in the EOC and PCP Agreement.
Quality Assessment and Performance Improvement (QAPI) – Access	▪ Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee. Substantial Compliance: The EOC should be revised to include this contract language. ▪ Each MCO… must implement mechanisms to assess each Medicaid enrollee identified by the State (through the mechanisms specified in paragraph (c)(1) of this section) and identified to the MCO… by the State as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment. Minimal Compliance: see care management file review. ▪ MCOs…to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring. Minimal Compliance: AHM's treatment plans were primarily disease-specific and centered on educational interventions. <u>Care Management File Review</u> Initially, of 20 files provided for review, many of the components needed for the review were not found in the files or could not be identified readily. AHM worked to retrieve additional documentation and flag the various file components (assessment, care plan). 10 of 20 files were reviewed. The results are as follows: 8/10 demonstrated collaborative care plan development. 1 of 10 files contained a reference to the care plan, but the care plan was not in the file. 1 of 10 was not applicable for this element as the member could not be contacted.

AHM: Summary of 2013 Medicare Managed Care Compliance Review Findings (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	3/10 demonstrated assessment of member needs. These assessments were in narrative format. 4 of 10 files contained only diabetes-specific assessments. 1 of 10 files contained a reference to an HRA, but it was not in the file. 1 of 10 files contained a partial assessment also in narrative format. 1 0f 10 files was not applicable for this element as the member could not be reached. AHM described a formal HRA but this was not found in the any of the files. 1/10 files demonstrated identification of goals and interventions. This was in narrative format in the notes. 8 of 10 files contained condition-specific care plans with only educational interventions and no goals. 1 of 10 files was not applicable for this element as the member could not be reached. 2/10 files demonstrated monitoring of progress toward goals. These were members discharged from an inpatient stay. 4 of 10 files contained notations regarding planned follow up but the follow up was not documented. 4 of 10 files were not applicable for this element as 3 members could not be reached and for 1 the review period ended shortly after enrollment in care
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ Each State must establish a uniform credentialing and recredentialing policy that each MCO… must follow. Each MCO… must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO. Minimal Compliance: see file review. ▪ Before any delegation, each MCO… evaluates the prospective subcontractor's ability to perform the activities to be delegated. Substantial Compliance: Annual evaluation reports for subcontractors were provided for delegated entities. No subcontracted entities were newly contracted within the period of review. ▪ Members may choose to disenroll for cause. Minimal Compliance: Policy did not address all areas for cause. <u>Summary of Credentialing and Re-credentialing File Review Findings (Total Files Reviewed: 20)</u>: PCP (10 files) All files contained an application with a signed statement from provider. All 10 files were Recredentialing; of those, only 1 file was recredentialed within 36 months of the initial credentialing. 5 files did not meet the 36 month requirement and 4 files did not include the initial credentialing date. Of the 10 files, all files contained license verification. Of those, 5 licenses were validated by the "Board of Good Standing"; the other 5 were validated only by a CD purchased from the State once every 6 months containing a listing of all providers with a valid license.

AHM: Summary of 2013 Medicare Managed Care Compliance Review Findings (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	Specialist (10 files) Of the 10 files reviewed, 9 were recredentialing. Of those, 6 were recredentialed within 36 months of the initial credentialing date. The remaining 3 had no initial credentialing date listed in the file. The 1 file submitted for initial credentialing was completed in a timely manner; however, the file did not contain evidence of verification of the provider's work history or residency/post-grad internship. Of the 10 files, all files contained license verification. Of those, 3 licenses were validated by the "Board of Good Standing"; the other 7 were validated only by a CD purchased from the State once every 6 months.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ Guidelines must consider the needs of the MCO's…enrollees. Substantial Compliance: No information was found in the documentation. ➢ Are adopted in consultation with contracting health care professionals. Substantial Compliance: Discussion of guidelines was not found in documentation. ➢ Are reviewed and updated periodically as appropriate. Minimal Compliance: Discussion of CPGs in the Quality Management Committee and UCMAC meeting was not seen. Medical Management committee meeting minutes were not found. ➢ Each MCO… disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Substantial Compliance. The policies do not address dissemination of guidelines. ➢ Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. Substantial Compliance: Evidence of consistency with guidelines for UM reviewers was not found. ▪ The State must review, at least annually, the impact and effectiveness of each MCO's… quality assessment and performance improvement program. The MCO's… performance on the standard measures on which it is required to report; and the results of each MCO's … performance improvement projects. Substantial Compliance: It was suggested that the evaluation could be improved by including a summary of the measurement results, analysis/interpretation and actions planned and taken. The date and approval signatures were not evident. ▪ The MCO's… performance on the standard measures on which it is required to report; and the results of each MCO's … performance improvement projects. Substantial Compliance: More detail, including the actual results, analysis of performance, and actions planned, as well as accomplishments in the current year and opportunities. Evaluation document. Including a description of the progress on the

AHM: Summary of 2013 Medicare Managed Care Compliance Review Findings (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	CCIP and QIP with next steps would improve the annual evaluation. ▪ The State must review, at least annually, the impact and effectiveness of each MCO's… quality assessment and performance improvement program. The review must include: ➢ The MCO's… performance on the standard measures on which it is required to report; and ➢ The results of each MCO are … performance improvement projects. Substantial Compliance: The QIPs are discussed briefly, only that 4 QIPs were performed and submitted to CMS. No analysis or next steps are provided. ▪ The State may require that an MCO have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. Substantial Compliance: Adding descriptions of completed and ongoing QI activities, analysis of results, barrier analysis and action plans as well as accomplishments for the current year and opportunities for the coming year would improve the annual evaluation. ▪ MCO maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart. Substantial Compliance. See above. ▪ Each MCO…comply with the following: ➢ Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State. Substantial Compliance: P&P not provided. ➢ Ensure that data received from providers is accurate and complete. Minimal Compliance: The documents provided for "Process for screening data for completeness, logic and consistency" do not address the requirement for internal quality measurement. ➢ Verifying the accuracy and timeliness of reported data. Minimal Compliance. ➢ Screening the data for completeness, logic, and consistency. Minimal Compliance. ➢ Collecting service information in standardized formats to the extent feasible and appropriate. Minimal Compliance. Documentation of validation of accuracy and completeness of encounter data, including analysis and follow-up" was not found. ➢ Make all collected data available to the State and upon request to CMS, as required in this subpart. Substantial Compliance. Policies and Procedures were not provided for the above.

AHM: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant	**Follow-Up Findings: Current Status**
Standard: Grievance System	
▪ Acknowledgement of receipt for member grievances, member appeals, and provider appeals – Substantial Compliance: One file for review could not be located; therefore, it could not be reviewed.	▪ 2013 Review Determination: Full Compliance
▪ Enrollee Right to request a Fair Hearing – Substantial Compliance: Not addressed in the letters of files reviewed for appeals.	▪ 2013 Review Determination: Full Compliance
▪ Procedures for enrollee to request a Fair Hearing – Substantial Compliance: Not addressed in the letters of files reviewed for appeals.	▪ 2013 Review Determination: Full Compliance
▪ The enrollee's right to have benefits continue pending resolution of appeal, how to request this, and circumstances in which the enrollee will be required to pay the costs of services – Substantial Compliance: Not addressed in the letters of files reviewed for appeals.	▪ 2013 Review Determination: Full Compliance
▪ Duration of continuation of benefits while the MCO appeal or Fair Hearing are pending – Substantial Compliance: Unable to verify in Member Handbook and P/P provided.	▪ 2013 Review Determination: Full Compliance
<u>Summary of Appeals File Review Findings (Total Files Reviewed: 24)</u>: ▪ Twelve member appeal files were reviewed. None of the files included the enrollee's right to have benefits continue pending resolution of the appeal, and the circumstances under which the enrollee may have to pay the costs of services. Twelve provider appeal files were reviewed. One requested file could not be located and was not provided. Of the 11 files reviewed, all files were compliant with most requirements. None of the files included the enrollee's right to have benefits continue pending resolution of the appeal, and the circumstances under which the enrollee may have to pay the costs of services. <u>Summary of Utilization Management File Review Findings (Total Files Reviewed: 12)</u>: Twelve utilization management files were reviewed. All files achieved 100% compliance with requirements.	▪ 2013 Review Determination: Full Compliance

AHM: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant	**Follow-Up Findings: Current Status**
Enrollee Rights and Protections	
▪ MCO provides required information to potential enrollees at required time frames – Non-Compliance: Marketing materials not submitted for review. Marketing is managed at MCO headquarters.	▪ 2013 Review Determination: Full Compliance
▪ MCO provides required information to potential enrollees – Non-Compliance: Marketing materials not submitted for review. Marketing is managed at MCO headquarters.	▪ 2013 Review Determination: Full Compliance
▪ MCO provides required information to potential enrollees – Substantial Compliance: Provider Directory does not address providers who are not accepting new patients.	▪ 2013 Review Determination: Full Compliance
▪ General information for all enrollees – Substantial Compliance: Provider Directory does not address providers who are not accepting new patients.	▪ 2013 Review Determination: Full Compliance
▪ MCO provides information to enrollees regarding coverage for emergency services – Non-Compliance: Member Handbook does not address information regarding emergency post-stabilization care.	▪ 2013 Review Determination: Substantial Compliance: Requirements for Emergency care evident in the EOC and Provider Pharmacy Directory. No communication of after-hours coverage.
▪ MCO notifies enrollees of additional information that is available on request, e.g., structure and operation of the MCO – Non-Compliance: Notification to enrollees not found in documents or P/P provided.	▪ 2013 Review Determination: Substantial Compliance Member Handbook (EOC) simply instructs members to call Customer Service for any additional information. Nothing specific to MCO structure and operations.
▪ MCO provides enrollees with information on provider incentives – Non-Compliance: Not addressed in documentation provided.	▪ 2013 Review Determination: Substantial Compliance: Not found in documents. Plans states not provided to membership.
▪ Written policies and procedures for Advance Directives, including all requirements – Substantial Compliance: No evidence of MCO staff education Advance Directives in P/P or staff orientation documents provided for review. No evidence in P/P related to provision of information that complaints concerning non-compliance may be filed with the State survey and certification agency.	▪ 2013 Review Determination: Full Compliance
Quality Assessment and Performance Improvement (QAPI) – Access	

AHM: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant	**Follow-Up Findings: Current Status**
▪ All requirements Fully Compliant.	
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	
▪ All requirements Fully Compliant.	
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	
▪ Performance Improvement Projects include an evaluation of the effectiveness of the interventions – Substantial Compliance: The *Ambulatory Follow-Up after Hospitalization for Mental Illness* did not achieve improvement at the time of re-measurement.	▪ 2013 Review Determination: Full Compliance

First Plus 2013 Medicare Compliance Review Findings for Contract Year 2012-2013

A summary of the Medicare compliance results for Humana Health Plan is provided below. For each standard, the following is provided: current year overall category compliance designations; a description of the current year findings for all standards/elements not found fully compliant, including a summary of the file review results, and HHP's response and action plan as applicable. Assessment of the effectiveness of the plan's progress for elements not fully compliant in the prior review follows the 2013 findings.

First Plus: Summary of 2013 Medicaid Managed Care Compliance Review Findings (Review Year 2012/2013)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	38	36	2	0	0
Enrollee Rights and Protections	46	41	5	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	44	38	6	3	2
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	21	20	1	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	31	14	11	1	5

First Plus: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
Grievance System	▪ Acknowledge receipt of each grievance and appeal. Substantial Compliance ▪ **Standard disposition of grievances.** For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State, but may not exceed 90 days from the day the MCO or PIHP receives the grievance. Substantial Compliance <u>Grievance File Review</u> A total of 20 grievance files were reviewed. Acknowledgment notices were present in 19/20 files <u>Appeal File Review</u> A total of 8 appeal files were reviewed. Acknowledgment notices were present in all files. Three of the 8 notices were untimely (greater than the plan standard of 5 days from date of receipt).
Enrollee Rights and Protections	▪ Enrollees have the right to file grievances and appeals. Substantial Compliance: Does not include language regarding members having the right to file grievances. ▪ Each MCO and PIHP has written policies regarding the enrollee rights specified in this section. Substantial Compliance: Policy not found in documents provided. ▪ MCO makes a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice. Substantial Compliance: Policies do not address the timeframe for notifying members. ▪ The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must provide the following information to all enrollees: The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers. Substantial Compliance: ASES phone number is in ANOC but language does not state how to contact the DOH for these services. ▪ How and where to access any benefits that are available under the State plan but are not covered under the contract. Substantial Compliance: ASES phone number is in ANOC but language does not state how to contact the DOH for these services.
Quality Assessment and Performance Improvement (QAPI) – Access	▪ MCO requires out-of-network providers to coordinate with respect to payment and ensures the cost to the enrollee is not greater than within the network. Substantial Compliance: Evidence of notification to out-of-network providers not found. ▪ MCO must meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services. Substantial Compliance: Documents provided did not include a policy/procedure addressing this requirement. ▪ Make services included in the contract available 24 hours a day, 7 days a week, when medically

First Plus: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	necessary. Substantial Compliance: Documents provided did not include a policy/procedure addressing this requirement. ▪ Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee. Substantial Compliance: No P&P was located that describes a PCP's responsibilities for coordination of care including BH services. ▪ Coordinate the services the MCO… furnishes to the enrollee with the services the enrollee receives from any other MCO. Substantial Compliance: Policies provided do not address coordination (of care) of services furnished to enrollees with services the enrollee receives from any other MCO. ▪ Direct access to specialists. For enrollees with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each MCO… must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs. Substantial Compliance: Policy/procedure addressing this requirement was not found in the documents provided. ▪ Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. Substantial Compliance: Documents provided did not include a policy/procedure addressing this requirement. ▪ Offers an appropriate range of preventive, primary care, and specialty services that are adequate for the anticipated number of enrollees for the service area. Minimal Compliance: Summary of monitoring results for the review period was not provided. Methods used to analyze monitoring results: Methods used to analyze monitoring results were not provided. Summary of actions taken as a result of monitoring results: Actions taken as a result of monitoring results were not provided. ▪ Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. Minimal Compliance: Summary of monitoring results for the review period was not provided. Methods used to analyze monitoring results: Methods used to analyze monitoring results were not provided. Summary of actions taken as a result of monitoring results: Actions taken as a result of monitoring results were not provided. ▪ Share with other MCOs… serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities. Minimal Compliance: Documents provided do not address sharing with other MCO's to prevent

First Plus: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	duplication of services/benefits. MA 07 Coordination of Care does not address sharing enrollee's information to prevent duplication of activities. ▪ Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary and Take corrective action if there is a failure to comply. Non-Compliance: Not addressed in documents provided. Did not locate evidence of implementation of corrective action for failure to comply with 24/7 access. ▪ Compensation of utilization management activities. Each contract must provide that, consistent with §438.6(h) and §422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee. Non-Compliance: Not addressed in documents provided.
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ Each MCO… must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO. Substantial Compliance. <u>Summary of Credentialing and Re-credentialing File Review Findings (Total Files Reviewed: 20)</u>: ▪ A total of 20 files were reviewed: 10 PCPs and 10 specialists. Three PCP files and 2 specialist files did not have a current application in the file.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ MCO… have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. Substantial Compliance: The topics in both the work plan and QI Evaluation are stated in broad categories, so it is difficult to determine if priorities identified in the prior year QI Evaluation are being specifically targeted in the work plan. For instance, HEDIS is stated but not a specific measure; CAHPS is stated but not a specific measure. ▪ Measure and report to the State its performance, using standard measures required by the State. Substantial Compliance: During the onsite review, it was noted that some reported results/goals should be verified. Some of these measures are inverse measures; First Plus should approach ASES to explore the possibility of accessing statewide results for comparative purposes. ▪ Submit to the State, data specified by the State, that enables the State to measure the MCO's … performance; or ▪ Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section. Substantial Compliance: During the onsite review, it was noted that some reported results/goals should be verified. Some of these measures are inverse measures; First Plus should approach ASES to

First Plus: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	explore the possibility of accessing statewide results for comparative purposes. ▪ MCOs … must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following: ➢ Evaluation of the effectiveness of the interventions. Substantial Compliance. ➢ Planning and initiation of activities for increasing or sustaining improvement. Substantial Compliance: The CCIP and QIP projects have not reached this phase. ▪ The State must review, at least annually, the impact and effectiveness of each MCO's… quality assessment and performance improvement program. The review must include: ➢ The MCO's… performance on the standard measures on which it is required to report; and ➢ The results of each MCO's … performance improvement projects. Substantial Compliance: The QIPs are discussed briefly, only that 4 QIPs were performed and submitted to CMS. No analysis or next steps are provided. ▪ The State may require that an MCO have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. Substantial Compliance: the QI Program Evaluation presents the results in broad categories. More detail can be seen in the Quality Monitoring Tool which tracks performance by measure. ▪ MCO…maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart. Substantial Compliance. ▪ Each MCO…comply with the following: ➢ Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State. Minimal Compliance: P&P not provided. ➢ Ensure that data received from providers is accurate and complete. Non Compliance: First Plus did not submit a P/P or process for verifying the accuracy and completeness of provider and vendor reported data. ➢ Verifying the accuracy and timeliness of reported data. Minimal Compliance. ➢ Screening the data for completeness, logic, and consistency. Minimal Compliance. ➢ Collecting service information in standardized formats to the extent feasible and appropriate. Minimal Compliance. ➢ Make all collected data available to the State and upon request to CMS, as required in this subpart. Minimal Compliance.

First Plus: 2013 Medicaid Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	Policies and Procedures were not provided for the above.

Humana Health Plan (HHP) 2013 Medicare Compliance Review Findings for Contract Year 2012-2013

A summary of the Medicare compliance results for Humana Health Plan is provided below. For each standard, the following is provided: current year overall category compliance designations; a description of the current year findings for all standards/elements not found fully compliant, including a summary of the file review results, and HHP's response and action plan as applicable. Assessment of the effectiveness of the plan's progress for elements not fully compliant in the prior review follows the 2013 findings.

Humana Health Plan: Summary of 2013 Medicare Managed Care Compliance Review Findings (Review Year 2012/2013)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	47	40	6	0	1
Enrollee Rights and Protections	49	40	7	0	1
Quality Assessment and Performance Improvement (QAPI) – Access	44	25	17	3	3
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	21	21	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	32	26	6	0	0

Humana Health Plan: 2013 Medicare Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
Grievance System	▪ Each MCO and PIHP must have a system in place for enrollees that include a grievance process, an appeal process, and access to the State's fair hearing system. Substantial Compliance: Policy does not address Maximus. ▪ For all appeals, the MCO or PIHP must provide written notice of disposition. Attempt to provide oral notice not found in policy. <u>Summary of Grievance File Review Findings (Total Files Reviewed: 20)</u>: ▪ Twenty grievance files were reviewed. ▪ All files were timely. ▪ 20 of 20 contained a letter of acknowledgement. <u>Summary of Appeal File Review Findings (Total Files Reviewed: 20)</u>: ▪ Twenty appeal files were reviewed. ▪ All files were timely. ▪ 20 of 20 contained a letter of acknowledgement. <u>Summary of Utilization Management File Review Findings (Total Files Reviewed: 20)</u>: ▪ UM File Review ▪ 18 of 20 files met the timeliness standard as measured from date of receipt to decision. ▪ 18 of 20 files contained a notice of action; all contained appeal procedures. ▪ No files contained a request for extension. ▪ 20 of 20 files NA for expedited requests.
Enrollee Rights and Protections	▪ All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats. Substantial Compliance: Policy does not include language on how to access the alternative formats. ▪ MCO, PIHP, PAHP, or PCCM must give each enrollee written notice of any change (that the State defines as "significant") in the information specified in paragraph (f)(6) of this section, and, if applicable, paragraphs (g) and (h) of this section, at least 30 days before the intended effective date of the change. Non-Compliance: Not addressed in documents provided. ▪ MCO must provide Procedures for obtaining benefits, including authorization requirements. Substantial Compliance: Enrollee Rights Policy does not specifically state "procedures for obtaining

Humana Health Plan: 2013 Medicare Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	benefits, including authorization requirements". ▪ MCO must provide the extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers. Substantial Compliance: Enrollee Rights Policy does not include "extent to which, and how enrollees may obtain benefits, including family planning services, from out-of-network providers". ▪ MCO must provide Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider. Substantial Compliance: No policy provided. ▪ MCO must provide Cost sharing, if any. Substantial Compliance: No policy provided. ▪ MCO must provide how and where to access any benefits that are available under the State plan but are not covered under the contract. Substantial Compliance: No policy provided. ▪ During the grievance process must provide the availability of assistance in the filing process. Substantial Compliance: Not included specifically in the policy.
Quality Assessment and Performance Improvement (QAPI) – Access	▪ MCO requires out-of-network providers to coordinate with respect to payment and ensures the cost to the enrollee is not greater than within the network. Substantial Compliance: Evidence of notification to out-of-network providers not found. ▪ Monitor providers for timely access regularly. Substantial Compliance: The MCO verbally reported conducting onsite audits of appointment availability, but no reports were provided. ▪ Takes corrective action for providers who do not comply with access and availability standards. Substantial Compliance: P/Ps were seen but results of monitoring were not provided. ▪ Share results of assessment of ISHCN with other MCOs to prevent duplication of services. Minimal Compliance: P/Ps do not address sharing information with other MCOs. ▪ Implement mechanisms to assess each Medicaid enrollee identified by the State with regard to special health care needs. Substantial Compliance. ▪ To produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment. Substantial Compliance. ▪ Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee. Substantial Compliance. ▪ Enrollees with special health care needs should have direct access to specialists. Substantial Compliance: Not addressed in policy provided ▪ Identify, define, and specify the amount, duration, and scope of each service that the MCO…is required to offer. Substantial Compliance: No policy provided.

Humana Health Plan: 2013 Medicare Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	▪ Require that the services be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid. Substantial Compliance: Policies do not specifically address FFS comparability. ▪ To notify the requesting provider, and give the enrollee written notice of any decision by the MCO… to deny a service authorization. Minimal Compliance: 18 of 20 files contained evidence of written notification to member, and 6 of 20 were without notice (written or verbal attempt) to contact provider. ▪ Privacy is protected for those enrollees who are receiving coordination of care services. Substantial Compliance: Confidentiality P/Ps address medical records, but are not specific to coordination of care. ▪ Consulting with requesting providers regarding authorizations when appropriate. Substantial: 2 medical necessity denials for continued inpatient stay did not contain evidence of consulting with requesting provider. ▪ Decision to deny or reduce a service authorization request is made by a health care professional with appropriate clinical expertise. Minimal Compliance: Files contained only the name of the person making the decision with no credentials and denial letters did not contain the Medical Director signature, therefore, appropriate health care professional could not be determined. ▪ Standard authorization decisions are provided as expeditiously as the enrollee's condition requires and within established timeframes. Substantial Compliance: 4 of 20 files did not meet the required notification timeframe. ▪ Possible extension if the enrollee, or the provider, requests extension. Substantial Compliance: No policy provided. ▪ The MCO…justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. Substantial Compliance: No policy provided. ▪ MCO…must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service. Substantial Compliance: No policy provided. ▪ The MCO…may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension. Substantial Compliance: No policy provided. ▪ Contracts provide that compensation to individuals/entities that conduct UM functions is not structured so as to provide incentives to deny or limit medically necessary services. Non-Compliance: Not address in the documents provided.

Humana Health Plan: 2013 Medicare Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	Summary of Care Management File Review Findings (Total Files Reviewed: 20): ▪ Twenty files were reviewed. ▪ 3 of 20 files did not have documented assessment. ▪ 3 of 20 files did not have evidence of a comprehensive care plan; 1 of the 3 did document monitoring of progress/interventions.
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ All requirements Fully Compliant. Summary of Credentialing and Re-credentialing File Review Findings (Total Files Reviewed: 20): ▪ Ten PCP credentialing/re-credentialing files were reviewed. All files were compliant with requirements. ▪ Ten Specialist credentialing/re-credentialing files were reviewed. All files were compliant with requirements.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ Conduct performance improvement projects as described in CMS regulations. Substantial Compliance: The Medicaid PIPs were not included in the QIC discussion/minutes and not included in the QI Evaluation. ▪ MCOs…must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. Substantial Compliance: As per above element. ▪ Ensure that data received from providers is accurate and complete by: ▪ Verifying the accuracy and timeliness of reported data; ▪ Screening the data for completeness, logic, and consistency; and ▪ Collecting service information in standardized formats to the extent feasible and appropriate. Substantial Compliance: Humana PR did not provide any documentation of quality measurement results of data received from providers and vendors for accuracy and completeness.

Humana Health Plan: 2013 Medicare Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant	**Follow-Up Findings: Current Status**
Standard: Grievance System	
▪ Oral inquiries seeking appeal are treated as appeals to establish the date of filing and must be confirmed in writing, unless an expedited appeal is requested – Substantial Compliance: Not addressed in P/P but evident in file review.	▪ 2013 Review Determination: Full Compliance
▪ MCO provides enrollee the opportunity to present evidence related to appeal – Substantial Compliance: Not addressed in P/P but evident in file review. P/P G&A 08-003 updated per plan response.	▪ 2013 Review Determination: Full Compliance
▪ Timeliness of grievance resolution within required time frame, but not greater than 90 days – Substantial compliance: One file not timely.	▪ 2013 Review Determination: Full Compliance
▪ Timeliness of standard appeal resolution not greater than 45 days (except if an extension is requested) – Substantial Compliance: One appeal file not compliant.	▪ 2013 Review Determination: Full Compliance
▪ Exceptions to mailing advance notice of action at least 10 days prior – Non-Compliance: Not addressed in documents provided.	▪ 2013 Review Determination: Full Compliance
▪ The period of advance notice may be shortened to 5 days if the MCO has verified cause to suspect probable fraud – Non-Compliance: Not addressed in documents provided.	▪ 2013 Review Determination: For Reference Only
Enrollee Rights and Protections	
Written policies and procedures for Advance Directives, including all requirements – Substantial Compliance: No evidence of community outreach or education activities regarding Advance Directives; however, information regarding Advance Directives is evident in policies and procedures, patient manual, and provider handbook.	▪ 2013 Review Determination: Full Compliance
Quality Assessment and Performance Improvement (QAPI) – Access	
▪ MCO must produce a treatment plan if warranted based on assessment for enrollees with special health care needs – Minimal Compliance: 7/10 care management files reviewed were non-compliant. <u>Summary of Care Management File Review Findings (Total Files Reviewed: 20)</u>:	▪ 2013 Review Determination: Substantial Compliance

Humana Health Plan: 2013 Medicare Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant	**Follow-Up Findings: Current Status**
▪ Twenty files were reviewed. Three files were not compliant with requirements to produce a treatment plan for enrollees with special health care needs.	
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	
▪ Evidence of distribution of clinical guidelines to providers and members – Substantial Compliance: Documentation provided does not address how guidelines are made available to members.	▪ 2013 Review Determination: Full Compliance
▪ General requirements for QAPI program – Minimal Compliance: 2010 QI Evaluation does not explicitly discuss PIP results; QI Work Plan sections for results, actions, assessment, analysis, and barriers are not completed on the documents provided. QI Committee minutes evidence minimal discussion of PIPs, CAHPS and HOS. QI Committee minutes do not reflect the responsibilities and functions stated in the P/P, including: review and analysis, and priority setting.	▪ 2013 Review Determination: Full Compliance
▪ The MCO ensures data received from providers is accurate and complete – Substantial Compliance: method for ensuring provider data is complete and accurate is not evident from documents provided	▪ 2013 Review Determination: Substantial Compliance Humana PR did not provide any documentation of quality measurement results of data received from providers and vendors for accuracy and completeness.
▪ The MCO verifies the accuracy and timeliness of data Substantial Compliance: It is not clear how data received from providers is validated.	▪ 2013 Review Determination: Substantial Compliance Humana PR did not provide any documentation of quality measurement results of data received from providers and vendors for accuracy and completeness.

Medical Card Systems (MCS) 2013 Medicare Compliance Review Findings for Contract Year 2012-2013

A summary of the Medicare compliance results for MCS is provided below. For each standard, the following is provided: current year overall category compliance designations; a description of the current year findings for all standards/elements not found fully compliant, including a summary of the file review results. Assessment of the effectiveness of the plan's progress for elements not fully compliant in the prior review follows the 2013 findings.

Medical Card Systems: Summary of 2013 Medicare Managed Care Compliance Review Findings (Review Year 2012/2013)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non- Compliance**
Grievance System	48	31	17	0	0
Enrollee Rights and Protections	52	43	6	0	2
Quality Assessment and Performance Improvement (QAPI) – Access	44	31	13	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	21	19	2	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	33	30	3	0	0

Medical Card Systems: 2013 Medicare Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
Grievance System	▪ The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the MCO's or PIHP's notice of action. Substantial Compliance: The plan should align time-frames in policies with communications. ▪ The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO or the PIHP; The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed appeal. Substantial Compliance: As per contract requirement, the plan should allow oral requests for all appeals – fast and standard – followed by a written, signed appeal. ▪ Notice of action must be in writing and must meet the language and format requirements of §438.10(c) and (d) to ensure ease of understanding. Substantial compliance: No equivalent UM medical policy was found. ▪ Notice of action content must include the action the MCO or PIHP or its contractor has taken or intends to take. Substantial compliance: No equivalent UM medical policy was found. ▪ Notice of action content must include the reasons for the action. Substantial compliance: No equivalent UM medical policy was found. ▪ Notice of action content must include the enrollee's or the provider's right to file an MCO or PIHP appeal. Substantial compliance: No equivalent UM medical policy was found. ▪ Notice of action content must include the enrollee's right to request a State fair hearing. Substantial compliance: No equivalent UM medical policy was found. ▪ Notice of action content must include the procedures for exercising the rights specified above. Substantial compliance: No equivalent UM medical policy was found. ▪ For termination, suspension or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213 and 431.214 of this chapter. Substantial compliance: Language regarding the 10 day advance notice (and exceptions) was not found. ▪ MCO must mail notice for denial of payment, at the time of any action affecting the claim. Substantial compliance: Language regarding denial of claim payment was not found in UM policies. ▪ MCO must mail notice for standard service authorization decisions that deny or limit services, within the time frame specified in 438.210(d)(1). Substantial compliance: No equivalent UM medical policy provided. ▪ If the MCO or PIHP extends the timeframe in accordance with §438.210(d)(1), it must – ▪ Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the

Medical Card Systems: 2013 Medicare Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	enrollee of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. Substantial compliance: No equivalent UM medical policy provided. ▪ For expedited service authorization decisions, give the enrollee written notice of the reason within the timeframes specified in §438.210(d). Substantial compliance: No equivalent UM medical policy provided. ▪ The process for appeals must provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. Substantial compliance: The right to present evidence is not specifically stated in the Appeals (QUAL-GA-018) or UM (CL-UTMAN 046) policies cited above. ▪ The process of appeals must provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process. Substantial compliance: Two case files were UTD. ▪ The written notice of the appeal resolution must include the results of the resolution process and the date it was completed. Substantial compliance: The date and results are not specified as part of the Resolution Letter in QUAL-GA-018 MCS Classicare Procedure for Handling Reconsideration Requests (Part C). <u>Summary of Grievance File Review Findings (Total Files Reviewed: 20)</u>: ▪ Twenty member grievance files were reviewed. All files were compliant with requirements. <u>Summary of Appeals File Review Findings (Total Files Reviewed: 20)</u>: ▪ 12 of 20 appeals files were found not-applicable. ▪ 8 of the remaining 8 files were compliant with requirements. <u>Summary of Utilization Management File Review Findings (Total Files Reviewed: 20)</u>: ▪ Twenty UM files were reviewed. All files were compliance with requirements.
Enrollee Rights and Protections	▪ MCO must notify all enrollees of their right to request and obtain the information listed in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least once a year. Substantial compliance: No evident policy in place regarding this requirement.

Medical Card Systems: 2013 Medicare Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	▪ MCO must furnish to each of its enrollees the information specified in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, within a reasonable time after the MCO… receives, from the State or its contracted representative, notice of the recipient's enrollment. Substantial compliance: Policy regarding new member communication not provided. ▪ MCO must give each enrollee written notice of any change (that the State defines as "significant") in the information specified in paragraph (f)(6) of this section, and, if applicable, paragraphs (g) and (h) of this section, at least 30 days before the intended effective date of the change. Substantial compliance: Policy addressing this requirement not provided. ▪ MCO must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Substantial compliance: Policy, Handbook and Letter were inconsistent with timing of notification. ▪ MCO must provide information to enrollees regarding Physician incentive plans as set forth in 438.6(h) of this chapter. Non-compliance: Not addressed in documents provided. ▪ Each MCO and PIHP has written policies regarding the enrollee rights specified in this section. Substantial compliance: Policy addressing this requirement not provided; however, Member Handbook and Provider Manual contain sections dedicated to Enrollee/Member Rights. ▪ Information on available treatment options and alternatives must be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. Non-compliance: Language regarding restraints and seclusion not specifically mentioned in E-EOC Platino Superior 2013 (Member Handbook) or Provider Manual. ▪ 417.436(d) Advance directives. Substantial compliance: Specific elements of education provided on advance directives were not contained in policy.
Quality Assessment and Performance Improvement (QAPI) – Access	▪ Provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. Substantial compliance: A policy addressing direct access was not provided. ▪ Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee. Substantial compliance: Policy does not specify "except for applicable co-pays". The "Evidence of Coverage" booklet states out-of-network services are not covered. The booklet and policy are inconsistent.

Medical Card Systems: 2013 Medicare Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	▪ MCO must meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services. Substantial compliance: A specific policy addressing access standards and appointment availability should be developed. ▪ MCO must ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. Substantial compliance: Addressed in Provider Manual on page 63, but not in policy. ▪ MCO must make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. Substantial compliance: Not found in policy, except regarding the procedure for telephonic consultation and emergency room access, but is included in the Sample PCP Contract. ▪ For enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with §438.208(c)(2)) to need a course of treatment or regular care monitoring, each MCO… must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs. Substantial compliance: Policy does not specifically address direct access. ▪ MCO must consult with the provider requesting authorization of services when appropriate. Substantial compliance: Not addressed in policy, but in Provider Manual. ▪ MCO to notify the requesting provider, and give the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing. Substantial compliance: Not found in policy, but in Provider Manual. ▪ For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days. Substantial compliance: No policy provided. ▪ For standard authorization decisions, provide notice with a possible extension of up to 14 additional calendar days if the enrollee, or the provider, requests extension. Substantial compliance: not addressed in policy. ▪ For standard authorization decisions, provide notice with a possible extension of up to 14 additional

Medical Card Systems: 2013 Medicare Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	calendar days if the MCO…justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. Substantial compliance: not addressed in policy. ▪ Expedited authorization decisions*:* For cases in which a provider indicates, or the MCO…determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO…must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service. Substantial compliance: Not found in policy, but in Provider Manual. ▪ Expedited authorization decisions: The MCO…may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO… justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. Substantial compliance: Not found in policy, but in Provider Manual. <u>Summary of Utilization Management File Review Findings (Total Files Reviewed: 20)</u>: ▪ Twenty UM files were reviewed. All files were compliance with requirements.
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	▪ Provider selection policies and procedures, consistent with § 438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Substantial compliance: Recommend to include '*nondiscrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment*' in the Credentialing Program Scope policy PR-CRED-02. ▪ The MCO… monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations. Substantial compliance: For JAYE (Telemedik) – The 2012 Annual Audit Summary was not provided.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ Measurement of performance using objective quality indicators. Substantial compliance: For QIP #3, indicator is inferred; indicator and target could be specified in QI Evaluation. ▪ Performance Improvement Projects: Evaluation of the effectiveness of the interventions. Substantial compliance: MCS did not submit the PIP proposals and status report documents. Including indicator targets for all QIPS in the QI Program Evaluation would support effectiveness. ▪ The results of each performance improvement project. Substantial compliance: Including indicator

Medical Card Systems: 2013 Medicare Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	targets for all QIPS in the QI Program Evaluation would support evaluation of effectiveness.

MCS: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant 2011	**Follow-Up Findings: Current Status**
Standard: Grievance System	
▪ Mailed advance notice at least 10 days prior to action – Non-Compliance: Not addressed in documents provided.	▪ 2013 Review Determination: Reference only. Not reviewed
▪ Exceptions to advance notice – Non-Compliance: Not addressed in documents provided.	▪ 2013 Review Determination: Reference only. Not reviewed
▪ Advance notice of action may be limited to 5 days in cases where the MCO has verified indications of probable fraud – Non-Compliance: Not addressed in documents provided.	▪ 2013 Review Determination: Reference only. Not reviewed
Summary of Grievance File Review Findings (Total Files Reviewed: 10): ▪ Ten grievance files were reviewed. ▪ All files were compliant with requirements.	▪ 2013 Review Determination: Summary of Grievance File Review Findings (Total Files Reviewed: 20): Twenty member grievance files were reviewed. All files were compliant with requirements.
Summary of Appeals File Review Findings (Total Files Reviewed: 20): ▪ Ten member appeal files were reviewed. ▪ All files were compliant with requirements. ▪ Ten provider appeal files were reviewed. ▪ All files were compliant with requirements.	▪ 2013 Review Determination: Summary of Appeals File Review Findings (Total Files Reviewed: 20): 12 of 20 appeals files were found not-applicable. 8 of the remaining 8 files were compliant with requirements.
Summary of Utilization Management File Review Findings (Total Files Reviewed: 10): ▪ Ten UM files were reviewed. All files were compliance with requirements.	▪ 2013 Review Determination: Summary of Utilization Management File Review Findings (Total Files Reviewed: 20): Twenty UM files were reviewed. All files were compliance with requirements.
Enrollee Rights and Protections	
▪ Written policies and procedures for Advance Directives, including all requirements – Substantial Compliance: No evidence of community outreach or education activities regarding Advance Directives; however, information regarding Advance Directives is evident in policies and procedures, patient manual, and provider handbook.	▪ 2013 Review Determination: Full compliance: E-EOC Platino Superior 2013 (Member Handbook) and Provider Manual contain language regarding the member's right to have an advance directive, including instructions on how to obtain one. Implementation of Education interventions regarding Advanced Directives policy CL-EDU-085.
Quality Assessment and Performance Improvement (QAPI) – Access	
▪ MCO must produce treatment plan for enrollees with special health care needs, based on assessment – Minimal Compliance: Three Care	▪ 2013 Review Determination: Not Applicable/State Obligation. Not Reviewed.

MCS: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant 2011	**Follow-Up Findings: Current Status**
Management files not compliant	
Summary of Care Management File Review Findings (Total Files Reviewed: 12): ▪ Twelve files were reviewed. ▪ Five files were for care coordination, not care management. ▪ Three of the remaining 7 files were not compliant with the requirement to produce a treatment plan for enrollees with special health care needs.	▪ 2013 Review Determination: Full Compliance
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	
▪ All requirements Fully Compliant.	▪ 2013 Review Determination: Two requirements were found to have substantial compliance.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	
▪ MCO has mechanism to detect under and over-utilization of services – Substantial Compliance: Utilization Review Committee established in 2009 to design a PIP to improve cost-effectiveness of care. Meeting minutes for 2010 document use of Emerald Reporting Tool and review of data for standard imaging, lab testing, and prescriptions per member per month.	▪ 2013 Review Determination: Full Compliance
▪ Methods to ensure that data received from providers is accurate and complete – Substantial Compliance: Documents provided do not provide clear evidence of how MCS ensures data received from providers is accurate and complete.	▪ 2013 Review Determination: Full Compliance
▪ Method to verify the accuracy and timeliness of reported data – Substantial Compliance: MCS validates its internal processing through the oversight of analysts, it is not clear how the data received from providers is validated.	▪ 2013 Review Determination: Full Compliance

MMM 2013 Medicare Compliance Review Findings for Contract Year 2012-2013

A summary of the Medicare compliance results MMM is provided below. For each standard, the following is provided: current year overall category compliance designations; a description of the current year findings for all standards/elements not found fully compliant, including a summary of the file review results, and MMM's response and action plan as applicable. IPRO will assess the effectiveness of the plan's corrective actions during the next annual compliance review.

MMM: Summary of 2013 Medicare Managed Care Compliance Review Findings (Review Year 2012/2013)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	48	45	3	0	0
Enrollee Rights and Protections	50	50	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	49	48	1	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	24	24	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	32	32	0	0	0

MMM: 2013 Medicare Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
Grievance System	▪ Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process. Substantial Compliance: The acknowledgement letters in the files reviewed did not contain the member's opportunity to examine the case file. ▪ For standard disposition of a grievance and notice to the affected parties, the timeframe may not exceed 90 days from the day the MCO or PIHP receives the grievance. Substantial Compliance: 1 of 20 standard grievances files was not resolved timely. ▪ The MCO or PIHP must provide the information about the grievance system to all providers and subcontractors at the time they enter into a contract. Substantial Compliance: Information about the grievance system for all subcontractors, including downstream entities was not found. <u>Summary of Grievance File Review Findings (Total Files Reviewed: 20)</u>: MMM: ▪ 20 grievance files were reviewed. ▪ 1 of 20 grievances was not resolved timely.
	<u>Summary of Appeals File Review Findings (Total Files Reviewed: 20)</u>: MMM: ▪ 20 appeal files were reviewed. ▪ All files were compliant with requirements. <u>Summary of Utilization Management File Review Findings (Total Files Reviewed: 20)</u> MMM ▪ 20 utilization management files were reviewed. ▪ All files were compliant with requirements.
Enrollee Rights and Protections	▪ All requirements fully compliant.
Quality Assessment and Performance Improvement (QAPI) – Access	▪ Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. Substantial Compliance: According to the plan's Provider Accessibility Report, MMM considers as compliant providers whose after-hours coverage is limited to an answering machine that instructs members to go the nearest emergency room. <u>Summary of Care Management File Review Findings (Total Files Reviewed: 20)</u> MMM

MMM: 2013 Medicare Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
	▪ 20 case management files were reviewed. ▪ All files were compliant with requirements.
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ All requirements fully compliant. <u>Summary of Credentialing & Re-credentialing Review Findings (Total Files Reviewed: 20)</u> MMM ▪ 10 credentialing files were reviewed. ▪ All files were compliant with requirements. ▪ 10 re-credentialing files were reviewed. ▪ All files were compliant with requirements.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ All requirements fully compliant.

MMM: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant 2011	**Follow-Up Findings: Current Status**
Standard: Grievance System	
▪ Time frame for expedited resolution of appeals – Resolution of appeals must occur no greater than 90 days – File review revealed one appeal not resolved timely	▪ 2013 Review Determination: Full Compliance
▪ Content for notice of appeal resolution – right to State Fair Hearing – Substantial Compliance: P/P for expedite appeals includes reference to enrollee right to State Fair Hearing, but does not address how to request this.	▪ 2013 Review Determination: Full Compliance
▪ Continuation of benefits – Substantial Compliance: P/P addresses requirements for continuation of benefits for inpatient admission only.	▪ 2013 Review Determination: Full Compliance
▪ Duration of continued or reinstated benefits – Substantial Compliance: P/P addresses requirements for continuation of benefits for inpatient admission only	▪ 2013 Review Determination: Full Compliance
▪ Enrollee responsibility for payment for services furnished while appeal is pending – Substantial Compliance: P/P addresses requirements for enrollee financial responsibility in the event of an adverse determination for inpatient admission only.	▪ 2013 Review Determination: Full Compliance
▪ MCO mails advance notice of adverse determination at least 10 days prior to date of action – Non Compliance: P/P addresses requirements for inpatient admission only.	▪ 2013 Review Determination: Full Compliance
▪ Exceptions to mailing advance notice of action at least 10 days prior – Non-Compliance: P/P addresses requirements for inpatient admission only.	▪ 2013 Review Determination: Full Compliance
▪ The period of advance notice may be shortened to 5 days if the MCO has verified cause to suspect probable fraud – Non-Compliance: P/P only addresses involuntary disenrollment due to fraud. Does not address advance notice for appeals in cases of suspected fraud.	▪ 2013 Review Determination: Full Compliance
Summary of Grievance File Review Findings (Total Files Reviewed: 20): MMM:	Summary of Grievance File Review Findings (Total Files Reviewed: 20): MMM:

MMM: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant 2011	**Follow-Up Findings: Current Status**
▪ Ten member grievance files were reviewed. ▪ All files were compliant with requirements.	▪ 20 grievance files were reviewed. ▪ 1 of 20 grievances was not resolved timely.
Summary of Appeals File Review Findings (Total Files Reviewed: 10): MMM: ▪ Ten member appeal files were reviewed. ▪ One expedited appeal file was not resolved timely.	Summary of Appeals File Review Findings (Total Files Reviewed: 20): MMM: ▪ 20 appeal files were reviewed. ▪ All files were compliant with requirements
Summary of UM File Review Findings (Total Files Reviewed: 12): ▪ Twelve utilization management files were reviewed. ▪ All files were compliant with requirements.	Summary of UM File Review Findings (Total Files Reviewed: 20) MMM ▪ 20 utilization management files were reviewed. ▪ All files were compliant with requirements.
Enrollee Rights and Protections	
▪ All requirements fully compliant.	▪ 2013 Review Determination: All requirements fully compliant.
Quality Assessment and Performance Improvement (QAPI) – Access	
▪ Treatment plan produced for enrollees with special health care needs – Substantial Compliance: File review evidenced one file not compliant with requirements.	▪ 2013 Review Determination: Full Compliance
Summary of CM File Review Findings (Total Files Reviewed: 7): ▪ Seven case management files were reviewed. ▪ One file was not compliant with requirement to produce a treatment plan based on assessment for enrollees with special health care needs.	Summary of CM File Review Findings (Total Files Reviewed: 20) MMM ▪ 20 case management files were reviewed. ▪ All files were compliant with requirements.
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	
▪ All requirements fully compliant.	▪ 2013 Review Determination: All requirements fully compliant.
Summary of Credentialing & Re-credentialing Review Findings (Total Files Reviewed: 12): ▪ Six credentialing files were reviewed. ▪ All files achieved 100% compliance with requirements. ▪ Six re-credentialing files were reviewed. ▪ All files achieved 100% compliance with requirements.	Summary of Credentialing & Re-credentialing Review Findings (Total Files Reviewed: 20) MMM ▪ 10 credentialing files were reviewed. ▪ All files were compliant with requirements. ▪ 10 re-credentialing files were reviewed. ▪ All files were compliant with requirements.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	

MMM: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant 2011	**Follow-Up Findings: Current Status**
▪ Performance Improvement Projects include implementation of system interventions to achieve improvement in quality – Substantial Compliance: The interventions for Potentially Harmful Drug-Disease Interaction PIP incorporated only provider-focused interventions. MMM/PMC should consider developing member-focused interventions for this PIP.	▪ 2013 Review Determination: All requirements fully compliant.

PMC 2013 Medicare Compliance Review Findings for Contract Year 2012-2013

A summary of the Medicare compliance results PMC is provided below. For each standard, the following is provided: current year overall category compliance designations; a description of the current year findings for all standards/elements not found fully compliant, including a summary of the file review results, and PMC's response and action plan as applicable. IPRO will assess the effectiveness of the plan's corrective actions during the next annual compliance review.

PMC: Summary of 2013 Medicare Managed Care Compliance Review Findings (Review Year 2012/2013)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	48	45	3	0	0
Enrollee Rights and Protections	50	50	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	49	48	1	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	24	24	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	32	32	0	0	0

PMC: 2013 Medicare Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
Grievance System	▪ Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process. Substantial Compliance: The acknowledgement letters in the files reviewed did not contain the member's opportunity to examine the case file. ▪ For standard disposition of a grievance and notice to the affected parties, the timeframe may not exceed 90 days from the day the MCO or PIHP receives the grievance. Substantial Compliance: 1 of 20 standard grievances files was not resolved timely. ▪ The MCO or PIHP must provide the information about the grievance system to all providers and subcontractors at the time they enter into a contract. Substantial Compliance: Information about the grievance system for all subcontractors, including downstream entities was not found. <u>Summary of Grievance File Review Findings (Total Files Reviewed: 20)</u>: PMC: ▪ 20 grievance files were reviewed. ▪ 19 of 20 files were resolved timely.
	<u>Summary of Appeals File Review Findings (Total Files Reviewed: 20)</u>: PMC: ▪ 20 appeal files were reviewed. ▪ All files were compliant with requirements with the exception of: 1 of 20 involved an appeal filed by the member's representative, but the file did not contain an AOR form. <u>Summary of Utilization Management File Review Findings (Total Files Reviewed: 20)</u> PMC ▪ This was not applicable, as all decisions were overturned upon appeal.
Enrollee Rights and Protections	▪ All requirements fully compliant.
Quality Assessment and Performance Improvement (QAPI) – Access	▪ Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. Substantial Compliance: According to the plan's Provider Accessibility Report, PMC considers as compliant providers whose after-hours coverage is limited to an answering machine that instructs members to go the nearest emergency room. <u>Summary of Care Management File Review Findings (Total Files Reviewed: 20)</u>

	PMC ▪ 20 case management files were reviewed. ▪ 7 of 20 were not compliant with monitoring of progress towards goals.
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ All requirements fully compliant. <u>Summary of Credentialing & Re-credentialing Review Findings (Total Files Reviewed: 20)</u> PMC ▪ 7 credentialing files were reviewed. ▪ All files were compliant with requirements. ▪ 13 re-credentialing files were reviewed. ▪ All files were compliant with requirements. ▪ 1 recredentialing file did not meet the 36 month requirement. However, the file that did not meet the timeframe showed evidence of multiple reminders sent to the providers to submit their applications
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ All requirements fully compliant.

PMC: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant 2011	**Follow-Up Findings: Current Status**
Standard: Grievance System	
▪ Time frame for expedited resolution of appeals – Resolution of appeals must occur no greater than 90 days – File review revealed one appeal not resolved timely	▪ 2013 Review Determination: Full Compliance
▪ Content for notice of appeal resolution – right to State Fair Hearing – Substantial Compliance: P/P for expedite appeals includes reference to enrollee right to State Fair Hearing, but does not address how to request this.	▪ 2013 Review Determination: Full Compliance
▪ Continuation of benefits – Substantial Compliance: P/P addresses requirements for continuation of benefits for inpatient admission only.	▪ 2013 Review Determination: Full Compliance
▪ Duration of continued or reinstated benefits – Substantial Compliance: P/P addresses requirements for continuation of benefits for inpatient admission only	▪ 2013 Review Determination: Full Compliance
▪ Enrollee responsibility for payment for services furnished while appeal is pending – Substantial Compliance: P/P addresses requirements for enrollee financial responsibility in the event of an adverse determination for inpatient admission only.	▪ 2013 Review Determination: Full Compliance
▪ MCO mails advance notice of adverse determination at least 10 days prior to date of action – Non Compliance: P/P addresses requirements for inpatient admission only.	▪ 2013 Review Determination: Full Compliance
▪ Exceptions to mailing advance notice of action at least 10 days prior – Non-Compliance: P/P addresses requirements for inpatient admission only.	▪ 2013 Review Determination: Full Compliance
▪ The period of advance notice may be shortened to 5 days if the MCO has verified cause to suspect probable fraud – Non-Compliance: P/P only addresses involuntary disenrollment due to fraud. Does not address advance notice for appeals in cases of suspected fraud.	▪ 2013 Review Determination: Full Compliance
Summary of Grievance File Review Findings (Total Files Reviewed: 20): PMC:	Summary of Grievance File Review Findings (Total Files Reviewed: 20): PMC:

PMC: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant 2011	**Follow-Up Findings: Current Status**
▪ Ten member grievance files were reviewed. ▪ All files were compliant with requirements.	▪ 20 grievance files were reviewed. ▪ 1 of 20 grievances was not resolved timely.
Summary of Appeals File Review Findings (Total Files Reviewed: 10): PMC: ▪ Ten member appeal files were reviewed. ▪ One expedited appeal file was not resolved timely.	Summary of Appeals File Review Findings (Total Files Reviewed: 20): PMC: ▪ 20 appeal files were reviewed. 1 of 20 involved an appeal filed by the member's representative, but the file did not contain an AOR form.
Summary of UM File Review Findings (Total Files Reviewed: 12): ▪ Twelve utilization management files were reviewed. ▪ All files were compliant with requirements.	Summary of UM File Review Findings (Total Files Reviewed: 20) PMC ▪ This was not applicable, as all decisions were overturned upon appeal.
Enrollee Rights and Protections	
▪ All requirements fully compliant.	▪ 2013 Review Determination: All requirements fully compliant.
Quality Assessment and Performance Improvement (QAPI) – Access	
▪ Treatment plan produced for enrollees with special health care needs – Substantial Compliance: File review evidenced one file not compliant with requirements.	▪ 2013 Review Determination: Full Compliance
Summary of CM File Review Findings (Total Files Reviewed: 7): ▪ Seven case management files were reviewed. ▪ One file was not compliant with requirement to produce a treatment plan based on assessment for enrollees with special health care needs.	Summary of CM File Review Findings (Total Files Reviewed: 20) PMC ▪ 20 case management files were reviewed. ▪ 7 of 20 were not compliant with monitoring of progress towards goals.
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	
▪ All requirements fully compliant.	▪ 2013 Review Determination: All requirements fully compliant.
Summary of Credentialing & Re-credentialing Review Findings (Total Files Reviewed: 12): ▪ Six credentialing files were reviewed. ▪ All files achieved 100% compliance with requirements. ▪ Six re-credentialing files were reviewed. ▪ All files achieved 100% compliance with requirements.	Summary of Credentialing & Re-credentialing Review Findings (Total Files Reviewed: 20) PMC ▪ 7 credentialing files were reviewed. ▪ All files were compliant with requirements. ▪ 13 re-credentialing files were reviewed. ▪ All files were compliant with requirements.

PMC: 2013 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant 2011	**Follow-Up Findings: Current Status**
	▪ 1 recredentialing file did not meet the 36 month requirement. However, the file that did not meet the timeframe showed evidence of multiple reminders sent to the providers to submit their applications.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	
▪ Performance Improvement Projects include implementation of system interventions to achieve improvement in quality – Substantial Compliance: The interventions for Potentially Harmful Drug-Disease Interaction PIP incorporated only provider-focused interventions. PMC/PMC should consider developing member-focused interventions for this PIP.	▪ 2013 Review Determination: All requirements fully compliant.

Triple S 2013 Medicare Compliance Review Findings for Contract Year 2012-2013

A summary of the Medicare compliance results for Triple S is provided below. For each standard, the following is provided: current year overall category compliance designations; a description of the current year findings for all standards/elements not found fully compliant, including a summary of the file review results. Assessment of the effectiveness of the plan's progress for elements not fully compliant in the prior review follows the 2013 findings.

Triple S: Summary of 2014 Medicare Managed Care Compliance Review Findings (Review Year 2012/2013)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	48	39	8	0	1
Enrollee Rights and Protections	50	43	4	2	1
Quality Assessment and Performance Improvement (QAPI) – Access	46	46	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	21	16	2	2	1
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	30	18	8	3	1

Triple S: 2014 Medicare Managed Care Compliance Review – Elements Not Fully Met (Review Year 2012/2013)	
Standard	**Description of Review Findings Not Fully Compliant**
Grievance System	▪ The MCO must mail the notice for standard service authorization decisions that deny or limit services, within the time frame specified. Substantial Compliance: P/P does not include specific timeframes. ▪ For expedited service authorization decisions, within the timeframes specified. Substantial Compliance: P/P does not include specific timeframes. ▪ Acknowledge receipt of each grievance and appeal. Substantial Compliance: 4 of 20 grievance files reviewed did not include a timely acknowledgment letter. 7 of 20 appeals files reviewed did not contain a timely acknowledgement letter. ▪ Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person and/or in writing. The MCO must inform the enrollee of the limited time available in the case of expedited resolution. Substantial Compliance: 5 of 20 appeal files reviewed did not inform the enrollee of the right to present evidence and limited time available if an expedited appeal. ▪ Provide the enrollee /representative the opportunity, before and during the appeals process, to examine the case file including medical records and any other documents and records. Substantial Compliance: 4 of 20 appeal files reviewed did not inform the enrollee of the right to examine the case file. ▪ Include, as parties to the appeal: the enrollee/representative; or the legal representative of a deceased enrollee's estate. Substantial Compliance: 6 of 20 appeal files reviewed did not address the enrollee parties to appeal. ▪ For standard disposition of a grievance and notice to the affected parties, the timeframe not to exceed 90 days from the day the MCO receives the grievance. Substantial Compliance: Of 20 grievance files reviewed, 18 were resolved timely, including 1 where the date of resolution was not evident for one file. ▪ The State must establish the method the MCOs and PIHPs will use to notify an enrollee of the disposition of a grievance/format of letters. Substantial Compliance: All but 1 of 20 grievance files reviewed included a resolution letter. ▪ The MCO must provide the information about the grievance system to all providers and subcontractors at the time they enter into a contract. Non-Compliance: This was not addressed in any of the documents provided. <u>Summary of Grievance File Review Findings (Total Files Reviewed: 20)</u>:

	▪ Twenty grievance files were reviewed (10 member, 10 provider). ▪ 11 of 20 grievance files did not contain an acknowledgement letter. ▪ 2 of 20 grievance files reviewed were not timely, including 1 where the date of resolution was not evident. ▪ All but 1 of 20 grievance files reviewed included a resolution letter. <u>Summary of Appeals Files Reviewed (Total Files Reviewed: 20)</u> ▪ Twenty appeals files were reviewed (10 member, 10 provider). ▪ 7 of 20 appeals files reviewed did not contain a timely acknowledgement letter. ▪ 5 of 20 appeal files reviewed did not inform the enrollee of the right to present evidence and limited time available if an expedited appeal. ▪ 4 of 20 appeal files reviewed did not inform the enrollee of the right to examine the case file. ▪ 6 of 20 appeal files reviewed did not address the enrollee parties to appeal. <u>Summary of UM Files Reviewed (Total Files Reviewed:20)</u> ▪ All files were fully compliant with the requirements.
Enrollee Rights and Protections	▪ The MCO… must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice. Substantial Compliance: ▪ The MCO..must provide the following information to all enrollees: names, locations, telephone numbers , non-English languages spoken by contracted providers, including identification of providers not accepting new patients. For MCOs… this includes, at a minimum, information on primary care physicians, specialists, and hospitals. Minimal Compliance: The Provider Directory states that “we don’t guarantee that each provider is still accepting new patients” although the MCO stated that all participating providers are required to accept new patients. ▪ Additional information that is available upon request, including information on the structure and operation of the MCO. Substantial Compliance: Evidence of Coverage did not contain specific information or reference to MCO structure and operations. ▪ The MCO has written policies regarding the enrollee rights: the right to Information on physician incentive plans. Minimal Compliance: No documentation that information regarding physician incentive plans is provided to members. ▪ The MCO has written policies regarding the enrollee rights: the right to request and receive a copy of his or her medical records, and request that they may be amended or corrected. Substantial Compliance: This right is not found in the MCO’s P/P on Member Rights and Responsibilities. ▪ Each enrollee is free to exercise his or her rights, and that the exercise of those rights does not

	adversely affect the way the MCO, its providers or the State agency treat the enrollee. Compliance: The Member Handbook and Member Rights and Responsibilities statement do not explicitly state that the member exercising his/her rights will not adversely affect how the member is treated.
Quality Assessment and Performance Improvement (QAPI) – Access	▪ All elements were fully compliant. <u>Summary of Care Management File Review Findings (Total Files Reviewed: 20)</u>: ▪ Twenty care management files were reviewed. ▪ All files were compliant with requirements.
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ Each MCO… must follow a documented process for credentialing and recredentialing of providers. Substantial Compliance: 3 of 20 cred/recred files were reviewed: 10 PCPs and 10 specialists. In three of the credentialing files (initial credentialing) that were reviewed, work history was listed and attested to by the physician but no check was done to verify the information provided. ▪ Each MCO… contract complies with the enrollment and disenrollment requirements and limitations set. Substantial Compliance: No documentation was found to demonstrate that enrollment/disenrollment requirements/limitations are communicated to providers. ▪ The MCO… monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule, consistent with industry standards or State MCO laws and regulations. Minimal Compliance: No evidence of ongoing oversight and formal annual review, such as annual review results, was found. ▪ If any MCO… identifies deficiencies or areas for improvement, the MCO… and the subcontractor take corrective action. Minimal Compliance: No evidence of ongoing oversight and formal annual review, such as annual review results, was found. ▪ The MCO… assures the agency that it does not request disenrollment for reasons other than those permitted under the contract. Non-Compliance: No documentation of MCO communication of disenrollment was found. ▪ Credentialing and Re-credentialing requirements – Substantial Compliance: For three re-credentialing files reviewed, the work history was not verified. <u>Summary of Credentialing & Re-credentialing Review Findings (Total Files Reviewed: 20)</u> ▪ 20 cred/recred files were reviewed (10 PCPs, 10 specialists). ▪ 3 of 20 files the work history was not verified.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ Each MCO…adopts practice guidelines. Substantial Compliance: A specific policy describing the plan's process for adopting/developing guidelines was not provided. ▪ Guidelines are based on valid and reliable clinical evidence or a consensus of health care

	professionals in the particular field. Substantial Compliance: Triple S cited local and national sources for CPGS, however, a P/P defining the process and stating sources was not provided. ▪ Guidelines consider the needs of the MCO's…enrollees. Substantial Compliance: A specific policy describing the plan's process for adopting/developing guidelines, including how needs of members are considered, was not provided. ▪ Guidelines are adopted in consultation with contracting health care professionals. Minimal Compliance: A specific policy describing the plan's process for adopting/developing guidelines, including how input from providers is incorporated, was not provided. ▪ Guidelines are reviewed and updated periodically as appropriate. Substantial Compliance: A specific policy describing the plan's process for adopting/developing guidelines, including the process and timeframes for review and revision, was not provided. ▪ The MCO must have an ongoing quality assessment and performance improvement program. Substantial Compliance: There was a noted increase in quality issues and grievances but no corresponding planning for intervention or further analysis. Most PIPs were not well described and status is only "completed" or "in process". It is not clear how the plan assesses quality for the Platino population distinct from MA. ▪ Each MCO … must report the status and results of each project to the State. Substantial Compliance: Documents only refer to CMS submission requirements. Submission to ASES not evident. ▪ The State must review, at least annually, the impact and effectiveness of each MCO's… quality assessment and performance improvement program. Substantial Compliance: It is not clear how QI activities for the Platino population are specifically evaluated. ▪ The MCO has in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. Minimal Compliance: The QI Evaluation is not Consistent with work plan for some elements. Quality audits are only generally mentioned with no specific findings. Specific actions for findings related to access, HEDIS and CAHPS findings are not present or not clear. ▪ Ensure that data received from providers is accurate and complete. Minimal Compliance: It is not evident from the documents provided how the plan assures the accuracy of data provided by its vendors and providers. ▪ The MCO must have a process for verifying the accuracy and timeliness of reported data. Minimal Compliance: It is not evident from the documents provided how the plan assures the accuracy of data provided by its vendors and providers. ▪ It is not evident from the documents provided how the plan assures the accuracy of data provided by its vendors and providers.

Triple S: 2014 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant 2011	**Follow-Up Findings: Current Status**
Standard: Grievance System	
Acknowledgement of receipt for member grievances, member appeals, and provider appeals – Non-Compliance: For most appeal and grievance files reviewed, no acknowledgement was sent.	▪ 2014 Review Determination: Substantial Compliance
MCO will ensure that individuals who make decisions on grievances and appeals were not involved in any previous level of review, are health care professionals with appropriate clinical expertise for cases of medical necessity, denial of expedited resolution of appeal, or for grievance or appeal involving clinical issues – Substantial Compliance: File review of appeals demonstrated one case was reviewed by the same provider as in the initial reverse determination.	▪ 2014 Review Determination: Full Compliance
Standard disposition of grievances – Substantial Compliance: File review of grievances demonstrated that processing of one case was not well coordinated across MCO departments.	▪ 2014 Review Determination: Substantial Compliance
Format of notices for grievances – Substantial Compliance: File review of grievances demonstrated that one final letter could not be located, unable to determine resolution.	▪ 2014 Review Determination: Substantial Compliance
Summary of Grievance File Review Findings (Total Files Reviewed: 20) ▪ 20 grievance files were reviewed (10 member and 10 provider). ▪ Many of 20 files lacked an acknowledgment letter. ▪ 1 of 20 files did not contain a resolution date or resolution. ▪ 1 of 20 files did not contain a resolution notice.	Summary of Grievance File Review Findings (Total Files Reviewed: 20): ▪ Twenty grievance files were reviewed (10 member, 10 provider). ▪ 11 of 20 grievance files did not contain an acknowledgement letter. ▪ 2 of 20 grievance files reviewed were not timely, including 1 where the date of resolution was not evident. ▪ 1 of 20 grievance files reviewed did not contain a resolution letter.
Summary of Appeal File Review Findings (Total Files Reviewed :24) ▪ 24 appeal files were reviewed (12 member and 12 provider). ▪ 1 of 24 appeal files was reviewed by a physician involved in the initial denial decision.	Summary of Appeals Files Reviewed (Total Files Reviewed: 20) ▪ Twenty appeals files were reviewed (10 member, 10 provider). ▪ 7 of 20 appeals files reviewed did not contain a timely acknowledgement letter. ▪ 5 of 20 appeal files reviewed did not inform the enrollee of the

Triple S: 2014 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant 2011	**Follow-Up Findings: Current Status**
	right to present evidence/limited time available if an expedited appeal. ▪ 4 of 20 appeal files reviewed did not inform the enrollee of the right to examine the case file. ▪ 6 of 20 appeal files reviewed did not address the enrollee parties to appeal.
Summary of UM File Review Findings (Total Files Reviewed: 10): ▪ 10 UM denial files were reviewed. ▪ All files were fully compliant with requirements.	Summary of UM Files Reviewed (Total Files Reviewed:20) ▪ 20 UM denial files were reviewed. ▪ All files were fully compliant with the requirements.
Enrollee Rights and Protections	
▪ All requirements were fully met.	▪ The MCO… must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice. Substantial Compliance: ▪ The MCO..must provide the following information to all enrollees: names, locations, telephone numbers , non-English languages spoken by contracted providers, including identification of providers not accepting new patients. For MCOs… this includes, at a minimum, information on primary care physicians, specialists, and hospitals. Minimal Compliance: The Provider Directory states that "we don't guarantee that each provider is still accepting new patients" although the MCO stated that all participating providers are required to accept new patients. ▪ Additional information that is available upon request, including information on the structure and operation of the MCO. Substantial Compliance: Evidence of Coverage did not contain specific information or reference to MCO structure and operations. ▪ The MCO has written policies regarding the enrollee rights: the right to Information on physician incentive plans. Minimal Compliance: No documentation that information regarding physician incentive plans is provided to members.

Triple S: 2014 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant 2011	**Follow-Up Findings: Current Status**
	▪ The MCO has written policies regarding the enrollee rights: the right to request and receive a copy of his or her medical records, and request that they may be amended or corrected. Substantial Compliance: This right is not found in the MCO's P/P on Member Rights and Responsibilities. ▪ Each enrollee is free to exercise his or her rights, and that the exercise of those rights does not
Quality Assessment and Performance Improvement (QAPI) – Access	
Treatment Plans based on assessment for enrollees with special health care needs – Substantial Compliance: P/P do not specifically address treatment plans for enrollees with special health care needs. (File reviewed did evidence treatment plans)	▪ 2014 Review Determination: All elements were fully compliant.
Summary of Care Management File Review Findings (Total Files Reviewed: 10): ▪ Ten case management files were reviewed. ▪ All files were compliant with requirements.	Summary of CM File Review Findings (Total Files Reviewed: 20): ▪ Twenty care management files were reviewed. ▪ All files were compliant with requirements.
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	
Credentialing and Re-credentialing requirements – Substantial Compliance: For three re-credentialing files reviewed, it was not evident if the provider was recredentialed every 36 months.	▪ Each MCO… must follow a documented process for credentialing and recredentialing of providers. Substantial Compliance: 3 of 20 cred/recred files were reviewed: 10 PCPs and 10 specialists. In three of the credentialing files (initial credentialing) that were reviewed, work history was listed and attested to by the physician but no check was done to verify the information provided. ▪ Each MCO… contract complies with the enrollment and disenrollment requirements and limitations set. Substantial Compliance: No documentation was found to demonstrate that enrollment/disenrollment requirements/limitations are communicated to providers. ▪ The MCO… monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule, consistent with industry standards or State

Triple S: 2014 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant 2011	**Follow-Up Findings: Current Status**
	MCO laws and regulations. Minimal Compliance: No evidence of ongoing oversight and formal annual review, such as annual review results, was found. ▪ If any MCO… identifies deficiencies or areas for improvement, the MCO… and the subcontractor take corrective action. Minimal Compliance: No evidence of ongoing oversight and formal annual review, such as annual review results, was found. ▪ The MCO… assures the agency that it does not request disenrollment for reasons other than those permitted under the contract. Non-Compliance: No documentation of MCO communication of disenrollment was found. ▪ Credentialing and Re-credentialing requirements – Substantial Compliance: For three re-credentialing files reviewed, the work history was not verified.
<u>Summary of Credentialing/Re-credentialing File Review Findings (Total Files Reviewed: 12)</u>: ▪ Six credentialing files were reviewed. ▪ All files achieved 100% compliance with requirements. ▪ Six re-credentialing files were reviewed. ▪ Three files did not provide evidence that the provider was re-credentialed every 36 months.	<u>Summary of Credentialing & Re-credentialing Review Findings (Total Files Reviewed: 20)</u> ▪ 20 cred/recred files were reviewed (10 PCPs, 10 specialists). ▪ 3 of 20 files the work history was not verified.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	
Performance Improvement Projects include an evaluation of the effectiveness of the interventions – Substantial Compliance: The Hemoglobin A1c PIP did not achieve improvement at the time of re-measurement.	▪ Each MCO…adopts practice guidelines. Substantial Compliance: A specific policy describing the plan's process for adopting/developing guidelines was not provided. ▪ Guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. Substantial Compliance: Triple S cited local and national sources for CPGS, however, a P/P defining the process and stating sources was not provided. ▪ Guidelines consider the needs of the MCO's…enrollees.

Triple S: 2014 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant 2011	**Follow-Up Findings: Current Status**
	Substantial Compliance: A specific policy describing the plan's process for adopting/developing guidelines, including how needs of members are considered, was not provided. ▪ Guidelines are adopted in consultation with contracting health care professionals. Minimal Compliance: A specific policy describing the plan's process for adopting/developing guidelines, including how input from providers is incorporated, was not provided. ▪ Guidelines are reviewed and updated periodically as appropriate. Substantial Compliance: A specific policy describing the plan's process for adopting/developing guidelines, including the process and timeframes for review and revision, was not provided. ▪ The MCO must have an ongoing quality assessment and performance improvement program. Substantial Compliance: There was a noted increase in quality issues and grievances but no corresponding planning for intervention or further analysis. Most PIPs were not well described and status is only "completed" or "in process". It is not clear how the plan assesses quality for the Platino population distinct from MA. ▪ Each MCO … must report the status and results of each project to the State. Substantial Compliance: Documents only refer to CMS submission requirements. Submission to ASES not evident. ▪ The State must review, at least annually, the impact and effectiveness of each MCO's… quality assessment and performance improvement program. Substantial Compliance: It is not clear how QI activities for the Platino population are specifically evaluated. ▪ The MCO has in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. Minimal Compliance: The QI Evaluation is not Consistent with work plan for some elements.

Triple S: 2014 Medicaid Managed Care Compliance Review – Follow-Up for Elements Not Fully Met in 2011 Review (Review Year 2012-2013)	
Description of Review Findings Not Fully Compliant 2011	**Follow-Up Findings: Current Status**
	Quality audits are only generally mentioned with no specific findings. Specific actions for findings related to access, HEDIS and CAHPS findings are not present or not clear. ▪ Ensure that data received from providers is accurate and complete. Minimal Compliance: It is not evident from the documents provided how the plan assures the accuracy of data provided by its vendors and providers. ▪ The MCO must have a process for verifying the accuracy and timeliness of reported data. Minimal Compliance: It is not evident from the documents provided how the plan assures the accuracy of data provided by its vendors and providers. ▪ It is not evident from the documents provided how the plan assures the accuracy of data provided by its vendors and providers.

HEDIS Findings

On January 1, 1997, CMS began requiring Medicare Advantage Organizations (MAOs) to report the HEDIS measures relevant to the Medicare population. MAOs must attempt to report every required measure, and report a numerator and a denominator even if the numbers are small, since comparing individual HEDIS results against aggregated levels of performance helps to assess performance in relation to other MAOs' performance as well as historical performance trends when compared to previous year results. The following measures were required for HEDIS 2013:

1. Colorectal Cancer Screening (COL)
2. Glaucoma Screening in Older Adults (GSO)
3. Care for Older Adults (COA)
4. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
5. Pharmacotherapy Management of COPD Exacerbation (PCE)
6. Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)
7. Osteoporosis Management in Women Who Had a Fracture (OMW)
8. Anti-depressant Medication Management (AMM)
9. Follow-up after Hospitalization for Mental Illness (FUH)
10. Annual Monitoring for Patients on Persistent Medications (MPM)
11. Medication Reconciliation Post-Discharge (MRP)
12. Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)
13. Use of High-Risk Medications in the Elderly (DAE)
14. Board Certification (BCR)

Below are the Platino results for HEDIS 2013. The rates highlighted in GREEN are above the NCQA Medicare mean.

Puerto Rico Platino HEDIS 2013 Summary

Measure	AMH 9233	MCS 10798	MCS 8882	MMM 10974	MMM 9228	PMC 9205	Trip S 8749	Trip S 10852
Effectiveness of Care: Prevention and Screening								
Colorectal Cancer Screening (col)	**69.98%**	**75.30%**	**70.98%**	**75.09%**	**66.67%**	**71.16%**	**71.74%**	**66.67%**
Glaucoma Screening in Older Adults (gso)	63.98%	**69.80%**	**73.83%**	67.38%	62.65%	65.76%	67.54%	62.26%
Care for Older Adults (coa)								
Advance Care Planning	12.58%	41.85%	**49.64%**	**66.18%**	19.95%	**65.94%**	17.00%	17.28%
Medication Review	23.84%	**67.64%**	**79.56%**	**82.73%**	53.04%	**87.10%**	22.96%	19.14%
Functional Status Assessment	23.84%	**71.78%**	**82.48%**	**81.27%**	20.44%	**86.13%**	38.19%	46.91%
Pain Screening	19.87%	**74.21%**	**85.40%**	**81.51%**	38.44%	**85.64%**	45.70%	46.30%
Effectiveness of Care: Respiratory Conditions								
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	23.51%	NA	18.62%	NA	27.21%	33.27%	28.57%	NA
Pharmacotherapy Management of COPD Exacerbation (pce)								
Systemic Corticosteroid	38.75%	41.46%	39.00%	NA	39.52%	46.89%	30.57%	NA
Bronchodilator	60.29%	57.32%	60.72%	NA	59.04%	61.52%	57.96%	NA
Effectiveness of Care: Cardiovascular								
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	92.82%	NA	**91.08%**	NA	82.87%	82.89%	NA	NA
Effectiveness of Care: Musculoskeletal								
Osteoporosis Management in Women Who Had a Fracture (omw)	18.83%	NA	16.87%	NA	12.75%	15.74%	24.00%	NA
Effectiveness of Care: Behavioral Health								
Antidepressant Medication Management (amm)								
Effective Acute Phase Treatment	**81.17%**	61.73%	54.15%	44.44%	44.07%	48.45%	53.19%	NA
Effective Continuation Phase Treatment	**76.73%**	44.44%	39.31%	24.07%	27.64%	35.09%	36.70%	NA
Follow-Up After Hospitalization for Mental Illness (fuh)								
30-Day Follow-Up	**63.69%**	**76.53%**	**78.76%**	NA	**73.30%**	55.97%	53.57%	NA
7-Day Follow-Up	24.92%	**40.82%**	**47.25%**	NA	**44.68%**	34.33%	28.57%	NA
Effectiveness of Care: Medication Management								
Annual Monitoring for Patients on Persistent Medications (mpm)								
ACE Inhibitors or ARBs	**93.81%**	**93.10%**	**93.57%**	**92.33%**	**93.50%**	**93.32%**	**94.09%**	91.43%

Measure	AMH 9233	MCS 10798	MCS 8882	MMM 10974	MMM 9228	PMC 9205	Trip S 8749	Trip S 10852
Digoxin	94.23%	**100.00%**	93.62%	NA	**94.83%**	**94.86%**	91.38%	NA
Diuretics	**94.75%**	**93.25%**	**94.12%**	**93.14%**	**93.94%**	**93.91%**	**94.36%**	**100.00%**
Anticonvulsants	54.93%	49.51%	44.52%	NA	54.12%	49.32%	51.97%	NA
Total	**91.73%**	91.10%	**91.85%**	90.70%	**92.34%**	**91.73%**	**92.48%**	**92.78%**
Medication Reconciliation Post-Discharge (mrp)	1.77%	1.65%	1.46%	7.69%	**27.01%**	8.03%	0.88%	NR
Potentially Harmful Drug-Disease Interactions in the Elderly (dde)								
Falls + Tricyclic Antidepressants or Antipsychotics	**26.32%**	NA	**21.54%**	NA	**18.32%**	**19.84%**	**25.53%**	NA
Dementia + Tricyclic Antidepressants or Anticholinergic Agents	**42.60%**	**49.35%**	**39.43%**	NA	**40.51%**	**29.61%**	**40.61%**	NA
Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs	**28.03%**	NA	**37.08%**	NA	**32.12%**	**29.28%**	**31.18%**	NA
Total	**39.44%**	**44.86%**	**35.63%**	**23.08%**	**35.37%**	**27.47%**	**37.23%**	NA
Use of High-Risk Medications in the Elderly (dae)								
One Prescription	**35.46%**	**37.49%**	**30.07%**	**29.52%**	17.31%	**33.97%**	**41.16%**	**37.65%**
At Least Two Prescriptions	**13.63%**	**12.20%**	**8.90%**	**14.10%**	2.53%	**17.46%**	**16.20%**	**13.58%**
Health Plan Descriptive Information								
Board Certification (bcr)								
Family Medicine	NR	1.38%	1.38%	NR	NR	NR	10.86%	10.86%
Internal Medicine	NR	8.05%	8.05%	NR	NR	NR	23.13%	23.13%
OB/GYN physicians	NR	16.16%	16.16%	NR	NR	NR	9.89%	9.89%
Pediatricians	NR	11.11%	11.11%	NR	NR	NR	11.52%	11.52%
Geriatricians	NR	35.29%	35.29%	NR	NR	NR	43.24%	43.24%
Other physician specialists	NR	21.75%	21.75%	NR	NR	NR	16.03%	16.03%

NR: not reported; NA: not applicable

Medicare Performance Improvement Projects

Background

This section of the report presents a summary of the Puerto Rico Medicare Performance Improvement Projects (PIPs) submitted by Humana Health Plan, Medical Card System (MCS), MMM/PMC, American Health Medicare, First Plus and Triple S for the calendar year 2012-2013.

The PRHIA requires that all contracted MCOs submit any and all PIPs, including ongoing PIPs, with a focus on clinical or non-clinical services provided to their Medicare managed care enrollees that were in process during the calendar year 2012-2013.

Methodology

IPRO prepared a summary for each of the PIPs reported by the six Medicare MCOs. The following attributes are described for each PIP:

- The study topic
- The study questions and indicators
- The study population and sampling strategy, if applicable
- The data collection procedures
- The interventions/improvement strategies
- The data analysis and results
- The achievement of improvement
- The achievement of sustained improvement, if applicable

Humana Health Plan (HHP) Medicare Managed Care
Performance Improvement Projects

The following narrative summarizes each of the two PIPs conducted by Humana Health Plan (HHP) that were in process during 2012 and 2013, and represent the most recent information reported to PRHIA.

PIP #1: Glaucoma Screening in Older Adults

Study Topic Selection:

The rationale for the study topic was not evidence-based. Humana presented general statistics in support of the topic (sources not identified) including the prevalence of diabetes & glaucoma, the anticipated rate of growth of glaucoma diagnoses and the effect on the elderly population (decreased quality of life and the ability to function independently). Humana stated that glaucoma is a diabetes related complication and that diabetics are at increased risk for developing glaucoma. The rationale did not explain why the PIP was focused on diabetic members with glaucoma when the HEDIS® measure Glaucoma Screening in Older Adults (GSO) measure applies to older adults in general, not specifically to people with diabetes. The Humana Quality Improvement Committee (QIC) chose the topic by conducting HEDIS® analysis and identified measures that fell below established goals and represented a significant amount of the membership.

Humana did not state how the topic was relevant specifically to the Medicare population it serves, other than to state that the purpose of the interventions was to increase members' knowledge of eye exam benefits and increase physician referral rates for eye exams, though physician referral rates for eye exams were not tracked during the study.

Study Question(s) and Indicator(s)

Humana did not identify a study question. The focus of the PIP is stated as a "Clinical project focused to improve glaucoma screening through provider and member education".

The PIP's study indicator was stated as the HEDIS® 2010 Glaucoma Screening for Older Adults: one or more eye exams for glaucoma by an eye care professional during the measurement year or the year prior to the measurement year.

Target/Goal

The goal for improvement was to achieve a rate of 62.3% based on the 2010 Quality Compass Average.

The objective(s) of the study were stated as:

- Increase members' knowledge of the benefits of an eye exam.
- Increase physician referral rates to eye care professionals for eye exams.

Study Population and Sampling:

The study population was defined as "…all Puerto Rico Humana Special Needs Plans' dual-eligible, in the SNP plan, 65 years and over, without a prior diagnosis of glaucoma or glaucoma suspect, who received a glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions of age who had a diagnosis of hypertension as outlined in the 2009 HEDIS specifications."

The inclusion criterion was stated as members 67 years and older as of December 31 of the measurement year. However, the description of the study population (above) gives the age criterion as members "65 years and over".

Exclusion criteria included members who had a prior diagnosis of glaucoma or glaucoma suspect as outlined in HEDIS 2010 specifications.

The denominator is stated as the "eligible population."
Humana should clarify whether the age criterion is 65 years or 67 years of age and specify that the population is NOT limited to those with a diagnosis of hypertension.

The baseline measurement period was calendar year 2009.
The interim measurement periods were calendar years 2010 and 2011.
The final measurement period was calendar year 2012.

The hybrid method was used. The total study population size was not provided nor was the sample size. The method for determining the sample size and the sampling method used were not included in the report.

Data Collection Procedures:

Data was collected from medical records and administrative data and was analyzed on an annual basis.

- Medical records: Humana collected retrospective data from medical records. The report did not include the number of data collection staff, the qualifications of the staff, the data collection tool or the specific guidelines for data collection.
- Administrative claims and\or encounter data: The report did not identify the specific source or database for the data or the methodology for collecting the data and calculating the indicator.

Methods used to ensure validity and reliability were not described and although this is a HEDIS measure, audit findings were not noted.

Interventions/Improvement Strategies:

The MCO identified the following barriers to improvement:

Provider-focused barrier was stated as: communicating members' gaps in care to provider is important and capturing correct and timely information is equally important.

The barrier was mitigated by utilizing a quarterly Member Gap Report and QI Nurse medical record review to identify members who lacked glaucoma screenings.

Member-focused barriers included:

- Cost barrier – Members were unable to afford the co-pay, if there was one.
- Knowledge deficit – Members were not aware that preventive glaucoma screening is a covered benefit with no co-pay.
- Members are more likely to trust and follow the advice of their personal physician.
- Members with other co-morbidities may be less likely to obtain their screenings as their focus is on the other health issues.

These barriers were mitigated by the Care Management staff providing additional education to members, care coordination and increasing the frequency of contacts with members outside of the PCP's office. The issue of members' lack of trust with providers other than their PCP was not addressed.

The interventions were as follows:

Provider-focused interventions:
Year One Intervention(s):

- The Quality Department Medical Directors presented HEDIS results to providers in 12/2010. This was a one-time event, with a reported 50% of members having received the intervention.

Humana should clarify how it was determined that 50% of members received this intervention or if this was meant to be 50% of providers.

Year Two Intervention(s):

- QI Nurses conducted medical record reviews and provided alerts when opportunities for preventive glaucoma screening services were identified. This was conducted annually for 100% of members.

Year Three intervention(s):

- Distributed Member Gap Reports to PCPs to identify members in need of glaucoma screening. This was done quarterly for 100% of primary care physicians.
- QI Nurses made visits to PCP offices and conducted medical record review to identify and resolve gaps in glaucoma screening. This was ongoing for 100% of members with gaps in care.

Member-focused interventions:
Year One Intervention(s): None
Since there was no member interventions in year one, the intervention strategy was very limited (only provider education).

Year Two Intervention(s):

- Case Management (CM) Nurses provided education about glaucoma screening to members enrolled in the CM program. This was Initiated in January 2011 and was an ongoing intervention that reached 1,027 members in 2011 (26.11% of the eligible population). Fifty percent of these members received a glaucoma screening eye exam. The percentage of the eligible population enrolled in the CM program was not provided.

Year Two Intervention(s):

- Case Management staff made phone call reminders to members with gaps in glaucoma screening to reinforce the importance of having a glaucoma screening. This was done for 100% of members.

Health Plan-focused intervention:

- No Health Plan-focused interventions were reported.

Humana could have explored reducing or eliminating co-pays to address this member barrier.

Additionally, the following intervention(s) were planned going forward:

Opportunities for improvement were identified, including revising the interventions and/or to deploying mitigation plans, although no specific revisions to the interventions or details for the mitigation plans were provided.

Data Analysis and Results:
The reported results are presented in the table below.

Humana Health Plans of Puerto Rico, Inc. PIP 2010-2012 Glaucoma Screening in Older Adults						
Indicator(s)	**Baseline Rate CY 2009**	**Year 1 Interim Rate CY 2010**	**Year 2 Interim Rate CY 2011**	**Year 3 Final Rate CY 2012**	**Target or Goal Rate**	**Target Or Goal Met?**
Glaucoma eye exam screening	41.00%	38.05%	51.05%	56.82%	62.30%	No

Meas Year	# Members Screened	% +/- from Baseline	# Eligible Members	% +/- from Baseline	Screening % Rate	% +/- from Baseline
2009	1267	N/A	3090	N/A	41.00%	N/A
2010	1305	+3%	3430	+11.00%	38.05%	-2.95 % pts
2011	2029	+60.14%	3933	+27.28%	51.05%	+10.05 % pts
2012	2888	+127.94%	5083	+64.45%	56.82%	+15.82 % pts

Achievement of Improvement:
Humana did not reach its target rate, however, although the screening rate initially declined by 2.95 percentage points in 2010, the rate then increased by 10.05 and 15.82 percentage points in 2011 & 2012, respectively.

Achievement of Sustained Improvement:
The PIP results improved consistently compared to the baseline rate in re-measurement years 2011 and 2012, but the MCO never achieved the target rate of 62.30%. The improvement in re-measurement years 2011 and 2012 corresponds with implementation of 4 of 6 interventions. Compared to baseline year 2009, there was a 127.94% increase in the rate of screening eye exams, almost twice the percentage increase in the overall eligible member population (64.45%). It is reasonable to state that the interventions had a positive effect on over of the course of the project.

Strengths:
- Humana selected a topic relevant to its membership which could result in improvement in early identification of & treatment of glaucoma to minimize disease progression.
- The PIP targets a chronic condition where improvement should result in decreased costs, decreased morbidity, improved member quality of life, functional status, health and satisfaction.
- The PIP demonstrated sustained improvement in glaucoma screening rates over a 3 year period.
- Humana utilized QI and Case Management Nurses to facilitate provider and member education, identify members in need of glaucoma screening, and provide direct contact with members.
- Five of 6 the interventions were ongoing efforts directed at positively impacting member and provider knowledge, provider identification of at risk members, and members obtaining glaucoma screenings.

Opportunities for Improvement:

- Humana did not directly state the study question – i.e., if the intervention will improve the outcome, in a question format.
- Humana should track physician referral rates for glaucoma screening exams and compare this to the number of completed screening exams to evaluate member compliance.
- The MCO should clarify whether the population includes all members age 67 or age 65, and that is not limited to only those with a diagnosis of hypertension.

Validation Findings

The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to fact that indicator specifications were not entirely clear: it is unclear whether HEDIS specifications were followed or modifications were made; the sampling method used was not identified, the data collection process was not fully described, and the methods for calculating the rates and ensuring reliability and validity were not provided.

PIP #2: Improving Post Discharge Care Coordination from Hospital (PDCC)

Following is a summary of the PIP conducted by Humana Health Plans of Puerto Rico, Inc. to address this topic.

Study Topic Selection:

Humana provided a strong rationale for its study topic selection. The rationale included Plan-specific and national statistics & information regarding the frequency of members (age 65 or older) re-admitted to the hospital within 30 days of discharge from the hospital. The PIP referenced the following:

- 2009 study by the New England Journal of Medicine that reported national readmission rates of 20% with an annual cost of $17 billion.
- The top 5 medical & top 5 surgical diagnoses associated with readmission and systemic factors (members, providers, health system) that affect readmission.
- Readmissions of the elderly occur frequently and are associated with inadequate follow up in the post discharge setting.
- Factors identified as causes of readmissions include poor patient self management, community infrastructure and awareness problems, insufficient patient support, medications discrepancies, long stays hospitalizations, lack of a follow-up appointment with the physician, confusion about medications, and confusion related to discharge instructions.
- Previous studies that focused on post discharge interventions & strategies that resulted in significant reductions in readmission rates.
- Humana referenced plan specific data - 2011 All Cause readmission rate = 18%. Humana's readmission rate is lower than the national average (18% versus 20%) but still represents an opportunity for improvement since the Plan's readmission rate is above the Medicare 4 Stars quality rating goal readmission rate of between >5% and < or = to 12%.
- This project aligns with the goals of the Health & Human services (HHS) initiative- Partnership for Patients, to decrease preventable complications during transitions from one care setting to anther so that hospital readmissions would be reduced.

Study Question(s) and Indicator(s):

Humana did not define a specific study question for this project. Humana's description for the PIP was described as "The focus of the Quality Improvement Project is to improve Post Discharge for members discharged from hospital setting" to close any potential gaps that may contribute to readmissions.

The main indicator for this PIP, "readmission rate", was not clearly specified as to timeframe (i.e. within 30 days of discharge), numerator criteria, denominator and methodology for calculating the measure (e.g. is reported rate unique members or admissions), although the report alludes to CMS technical specifications for All Cause Readmission in the rationale; the methodology for calculating the indicator should be clarified in the report. The basis of the Plan selecting hospital readmission rates for study is based on national statistics related to readmission rates and costs, identification of the top 5 medical & surgical reasons for readmission and anecdotal evidence from previous studies that positively correlate post discharge coordination of care with decreased readmission rates. The Plan set a member readmission goal rate of 12% which would be in line with the Medicare Stats quality rating 4 threshold for this measure. The 4 Star quality rating establishes a readmission goal of > 5% but < or = 12%. (Source: see pp 28-29 https://www.scanhealthplan.com/documents/quality-improvement/2012_Tech_Notes_2012_01_18.pdf). Planned process measures included number of

eligible members contacted post discharge and number of eligible members contacted within three business days of discharge.

Study Population and Sampling:

The study population is the Plan's members 65 years of age and older that were discharged from the hospital setting to home. Members who were discharged to skilled nursing homes or rehab facilities were excluded from the study. There was no sampling in the study. All eligible members were included in the study.

Data Collection Procedures:

Data for the study was collected from administrative Claims Data. The plan did not specify data collection procedures other than query of claim data for readmissions, but do cite using CMS technical specifications for All Cause Readmission for benchmarks.

Data was collected for the baseline year 2012 and first measurement year 2013, resulting in a total of two measurement periods – a baseline and one (1) re-measurement.

Interventions/Improvement Strategies:

Provider-focused interventions:

- Provider interventions were not conducted, as the focus of the QIP was to develop a procedure for the Plan to increase post discharge contact with members following hospital discharge.

Member-focused interventions:

Outreach to members and completion of the Case Management Post Discharge Assessment Tool by the Case\Disease Management staff with the member. Elements evaluated during the assessment include:

- Discharge planning confirmation
- Understanding of discharge planning
- Follow-up appointment scheduled
- Medications ordered upon discharge
- Identification of barriers to care (e.g. financial, social, transportation or access)
- Identification of adequate outpatient support

The post discharge care coordination (PDCC) improvement process focuses on timely, risk stratified post-discharge care coordination interventions, especially for high risk members. PDCC activities include but are not limited to the following:

- Identify members at risk for readmissions to acute care through the Case Management Post Discharge Assessment Tool.
- Perform a clinical evaluation within 72 hours of discharge to enforce changes in the member's care plan, reassess clinical status in the home setting and mitigate exacerbations
- Implement coordination of care with Disease Management for members with specific chronic conditions (including COPD, Asthma, Diabetes, CAD and CHF)
- Implement member education interventions to increase members ability to properly manage their own health conditions or use of medications
- Implement coordination of care with primary care physicians or specialists in order to ensure post discharge follow up
- Implement social work evaluation to address specific member's needs.

Health Plan-focused intervention(s):

Baseline year (2012) interventions: Humana assessed possible barriers to improvement when reviewing the baseline and year one data.

Interventions reviewed and implemented during baseline year 2012 and re-measurement year 2013 include:

- Eligible members discharged to home will have a clinical outreach attempted within 3 business days of discharge to complete Post Discharge Assessment Tool. Assessment is designed to evaluate member's needs and close identified gaps in care.
- Members Admission Report will be available to the Case\ Disease Management teams on a daily basis to identify members who had a hospital admission.
- Utilization of Case Management and Disease Management case managers in the post discharge coordination process. Members already enrolled in Case Management programs will have outreach by their current case manager. Remaining members will be assigned to a case manager for outreach.

Barriers encountered during baseline year 2012 and re-measurement year 2013 were a lack of phone numbers, no answer, a lack of accurate report to identify admissions and prioritization of members' calls to complete other assessments.

Plan to mitigate the barriers encountered during the baseline year 2012 and re-measurement year 2013 were:

- Improve members outreach
  - o Continue call attempts up to 15 business days after discharge
  - o Calls to PCP's office to validate member phone numbers
  - o Referral to Face to Face case managers for home visits after the 15th day call
  - o Training to Marketpoint Sales representatives to ensure complete and accurate member information is submitted trough the enrollment process
- Revision of the Daily Admission report was performed in collaboration with Health Care Economics team to improve report. Mitigation will help improve data accuracy to eliminate admissions that have not yet occurred for planned elective procedures.
- Realignment of processes through the designation of dedicated resources to perform members calls instead to having all case managers performing member calls. New process will ensure that post discharge calls are completed as planned.
- Dedicated case managers will work closely with Face to Face case managers to make the appropriate transition of members.

Additionally, the following interventions were planned going forward:

- Implement an initiative to inform physicians about member's admissions to the hospital.
- Engage Utilization Management Concurrent Review in reporting member admissions and discharges to Post Discharge program through Case Management system.

Data Analysis and Results:

Humana's goal was to achieve a 3 percentage point reduction (15% to 12%) of All Cause readmissions within 30 days of hospital discharge for members 65 yrs of age and older.

Metrics were pulled from Case Management program metrics in order to track the following:

- The number of eligible members contacted post discharge (these results were not reported in the PIP)
- The timelines of the contacts: Number of eligible members contacted within 3-business day of discharge with complete post discharge outreach (these results were not reported in the PIP).
- Claims data was queried to track: total members admitted in the measurement years and the readmission rate of members in the measurement years.

Reported results were as follows:

- The Plan reported that in the year prior to this PIP study, the Plan's 2011 results data showed that the readmission rate was 18% for this population.
- The reported 2012 baseline was a 15% readmission rate. In 2012, the population is reported to be 1,071 admissions (or members, not labeled) with 131 readmission which the plan reports as a 15% readmission rate. **Note: the calculation of the rate using the reported numerator and denominator is 131/1071 = 12.2%, not 15%.**
- In 2013, the reported population is 1,135 with 168 readmissions, which is reported as a 12% readmission rate. Note: the calculation of the rate using the reported numerator and denominator is 168/1135 = 14.8%, not 12%.
- The plan should verify reported rates; it is possible that baseline and first remeasurement reported rates have been transposed in the table. The reported numerators, denominators and rates should be consistent with the plan's statement that the readmission rate fell from 15% in 2012 to 12% in 2013.

The results for the measurement during the 2012-2013 periods are presented in the table below. The QIP document stated that the 15% baseline rate and goal of a 3% reduction was established in comparison to the Medicare Stars rating 4 threshold. The 12% goal rate (a 3 percentage point reduction from baseline) would be in line with the Medicare Starts rating 4 threshold. The rating 4 threshold established a readmission goal of greater than 5% but less than \ equal to 12%.

- The project will continue in 2014 and a second remeasurement readmission rate for the project is to be determined upon project completion.
- The PIP report includes a statement that "The plan post discharge program resulted in a 5 percentage point reduction in the All Cause Readmission measure, exceeding the established goal." The data reported by the Plan does not provide any verifiable data to support this statement, unless the 2011 rate of 18% readmission rate was used as the baseline rate. In this study the baseline rate was 15% from 2012 data.

Humana Health Plans of Puerto Rico, Inc./CARE PIP 2012-2014 Improving Post Discharge Care Coordination from Hospital (PDCC)					
Indicator(s)	**Baseline Rate 2012**	**Interim Rate Y1 - 2013**	**Final Rate Y2 - 2014**	**Target or Goal**	**Target or Goal Met?**
% members readmitted to the hospital within 30 days of discharge.	15%	12%	N/A	12%	Yes

Achievement of Improvement:

The indicator of **"%** members readmitted to the hospital within 30 days of discharge" showed improvement from a baseline rate of 15% in 2012 to a rate of 12% in 2013 if numerators and denominators were transposed and reported rates are accurate. The 12% rate met the Plan's goal rate for this QIP. The Plan needs to verify the accuracy of the reported data; if numerators and denominators were not transposed, improvement was not achieved.

Achievement of Sustained Improvement:

This PIP project will continue through 2014. A determination of the sustained improvement will be dependent on review of 2014 results in comparison to 2012 & 2013 results.

Strengths:

- Humana selected a topic relevant to its membership and for which evidence-based interventions could result in substantial improvement by reducing hospital readmissions, improving member overall health and increasing member satisfaction.
- The PIP targets hospital readmissions, which lead to increased potentially preventable costs and where improvement should result in better health outcomes for members by promoting access to preventive care.
- Humana developed a comprehensive process for assessing post discharge members for coordinating post discharge care and ideally preventing members' hospital readmission.
- Involvement of Case Management and Disease Management case managers enables the plan to focus on members with special healthcare needs who are at higher risk for readmission.
- The Member admission report is produced on a daily basis for early identification of member hospital admissions.
- The plan identified opportunities to positively impact members during and after a member's hospitalization. The Plan intends to implement an initiative to inform physicians about member admissions to the hospital. The Plan also plans to engage Utilization Management Concurrent Review in reporting member's admissions and discharges to Post Discharge program through Case Management system.

Opportunities for Improvement:

- Interventions targeting Providers, such as the planned intervention to notify providers about member admissions and readmissions, would enhance the project.
- The Plan should report and track the project's identified process measures to evaluate reach and effectiveness of interventions.
    1. Evaluating rates of contact (number contacted/eligible members) would provide more information than counts alone. Tracking engagement rates, i.e. the number of members

contacted who agreed to participate in the post discharge program/number contacted would facilitate evaluation of interventions.

2. Stratification of readmission rates by identified conditions of interest could allow more intensive interventions to be focused on members who are considered high risk, who would benefit most from the program.

- Indicators should be clearly defined with numerators and denominators and methodology for calculation of rates. Clear labeling of the data in results tables will prevent any opportunity for misinterpretation of data.
- Since contacting members post discharge is a major barrier, the Plan, if feasible, could consider initiating contact for discharge planning prior to hospital discharge. This could also increase the accuracy of member demographic and contact information which would increase the likelihood of successfully contacting and following up with members after discharges.
- Interventions were begun during the baseline year; the plan should note this limitation in interpreting results.

Validation Findings

There are one or more validation findings that indicate a bias in the PIP results as reported. Conclusions of improvement due to interventions are uncertain due to discrepancies in calculation and reporting of readmission rates, lack of reporting of reach or interventions (process measures), and lack of clear description of methodology of determining readmission rates.

American Health Medicare (AHM)
Medicare Performance Improvement

The following narrative summarizes each of the PIPs conducted by American Health Medicare (AHM) that were in process during the 2012-2013 contract periods.

PIP #1: Managing members with a diagnosis of hypertension / hypercholesterolemia and with uncontrolled diabetes mellitus as defined by Hemoglobin A1C above 8mg/dl.

Following is a summary of the PIP conducted by American Health Medicare (AHM) to address this topic.

Study Topic Selection:

AHM provided an evidence-based rationale for selecting the study topic. The Plan presented national (sources unknown), regional and plan-specific statistics in support of the topic including the costs & prevalence of diabetes, the prevalence of the plan's diabetic membership with poor control of co-morbid conditions of hypertension & hypercholesterolemia and the 4-times higher rate of mortality due to cardiac conditions for diabetics than for non-diabetics. The study is relevant to the Plan's membership which has a high prevalence of diabetes (34%) and of diabetics with poor blood pressure (50%) and poor cholesterol control (67%).

Study Question(s) and Indicator(s):

AHM did not identify a study question. The PIP will target members with a diagnosis of hypertension and/or hypercholesterolemia and with uncontrolled diabetes with A1C over 8mg/dl . The stated focus of the PIP is secondary prevention to diminish short and long term effects of hypertention / hypercholesterolemia in the selected uncontrolled diabetic population.

AHM has established 7 main measures used for the PIP that will be monitored on a monthly and quarterly basis depending on the measure:

- members identified without a glycosylated hemoglobin performed; target 80%. glycosylated hemoglobin performed (if applicable if uncontrolled) post interventions; target 70%.
- members who are aware of their blood pressure results; target 70%.
- medication adherence:
  - medication adherence for diabetic medication; target 80%.
  - medication adherence for cholesterol lowering agents; target 60%.
  - medication adherence for antihypertensive drugs; target 80%.
- glycosylated hemoglobin below 8; target 80%.
- Low Density Lipoprotein below 100; target 60%.
- members on either ACE inhibitor or ARB's; target 70%.
- members who smoke who are referred to a formal Smoking Cessation Program; target 80%.

The PIP states that uncontrolled hypertension is the primary risk factor for the macro vascular complications of diabetes, and makes an unclear statement of "Control is defined as between 30% to 53% using the most conservative standards." The PIP's goal is to improve the number of members with controlled blood pressure by 25%. The benchmark is based on the Plan's own population (internal data and trends) and from external data: Medicare Health & Drug Plan Quality and Performance Ratings 2012 Part C & Part D. The PIP does not identify an indicator for tracking blood pressure rates for members

included in the study, and lists member knowledge of blood pressure rather than controlled blood pressure as a metric.

Study Population and Sampling:

The study population is defined as active plan members with a continuous enrollment of at least three months and continuous membership for at least two quarters. The diagnoses included are: Hypertension (209. XX), Hyperlipidemia (272.0) with Uncontrolled Diabetes Mellitus with A1C over 8mg/dl (250.xx). Members are automatically included in the study unless they opt out. Members included in the study are identified from Health Risk Assessments, Utilization Management data, Registry data, administrative claims data, enrollment data and case management referrals.

- Numerator: the number of members with a diagnosis of Hypertension/and or hyperlipidemia with uncontrolled diabetes as evidenced by A1c over 8mg/dl with intervention.
- Denominator: the total of cases with a diagnosis of Hypertension/and or hyperlipidemia with uncontrolled diabetes as evidenced by A1c over 8mg/dl.
- Exclusion criteria: membership of less than three months at the start of the project; inactive members without a continuous enrollment of 6 months; and non-contact members.

The study does not identify any sampling methods to be used in the study.

Data Collection Procedures:

- Data will be collected from the following data sources: administrative Claims data, Plan data, Health Risk Assessments, HEDIS® data, Registries and utilization review audits. The PIP does not identify the methodology for collecting data and calculating data results.

Interventions/Improvement Strategies:

Member-focused interventions:

Baseline year interventions:

- Interventions are based on the member's stratification. Low and moderate risk members will participate in mailings and general educational interventions. For higher risk members educational interventions are more aggressive.
- AHM will provide self-management education to equip members with the knowledge and skills to actively participate in their care, make informed decisions, set collaborative goals, carry out daily management, evaluate treatment outcomes, and communicate effectively with the health care team.
- Care managers and coordinators will call regularly and according to risk identification/stratification of members. Educational material and information is sent to population (selected) according to identified needs.
- Tele-medicine Diabetes 24/7 support.

Member interventions focus on the diabetes disease process, treatment options, nutritional management, physical activities, treatment adherence, safe medication usage, blood pressure monitoring and self management, detecting and treating acute & chronic complications, addressing psychosocial issues, health promotion and general preventive measures.

No member-focused barriers are identified in the PIP.

Provider-focused interventions:

- WEB portal (autoservice portal), Newsletters, Quarterly Meetings and monthly meetings. Individual interventions for Phamacy management. Through the portal, providers get updated information about guidelines and procedures that will have an impact in their practice and in the secondary prevention for these conditions.
- In the second quarter of 2012, the Plan implemented a Health Risk Evaluation (epass) that trains and educates physicians about evidenced-based management.

The PIP states that it will monitor the number and percentage of providers impacted by interventions, individual clinical measures and outcomes (by providers). The PIP does not identify specific goal rates for provider outreach effectiveness.

No provider-focused barriers are identified in the PIP.

Health Plan-focused intervention(s):

- Health Plan-focused interventions are not applicable to this study.

Additionally, the following intervention(s) were planned going forward:

- Not applicable at this time since this PIP appears to be in the development phase.

Data Analysis and Results:

No results were reported, as it appeared the project was in the development phase.

AHM Healthcare PIP 2012-2017 Managing members with a diagnosis of hypertension / hypercholesterolemia and with uncontrolled diabetes mellitus as defined by a Hemoglobin A1C above 8mg/dl						
Indicator(s)	**Baseline Rate 2014**	**Interim Rate 2015**	**Interim Rate 2016**	**Final Rate 2017**	**Target or Goal**	**Target or Goal Met?**
Members without a glycosylated hemoglobin performed	TBD	TBD	TBD	TBD	80%	TBD
Members with a glycosylated hemoglobin performed post interventions	TBD	TBD	TBD	TBD	70%	TBD
Members aware of their blood pressure results	TBD	TBD	TBD	TBD	70%	TBD
Diabetic medication compliance	TBD	TBD	TBD	TBD	80%	TBD
Cholesterol lowering medication compliance	TBD	TBD	TBD	TBD	60%	TBD
Anti-hypertensive	TBD	TBD	TBD	TBD	80%	TBD

AHM Healthcare PIP 2012-2017 Managing members with a diagnosis of hypertension / hypercholesterolemia and with uncontrolled diabetes mellitus as defined by a Hemoglobin A1C above 8mg/dl						
Indicator(s)	**Baseline Rate 2014**	**Interim Rate 2015**	**Interim Rate 2016**	**Final Rate 2017**	**Target or Goal**	**Target or Goal Met?**
medication compliance						
glycosylated hemoglobin < 8%	TBD	TBD	TBD	TBD	80%	TBD
LDL < 100	TBD	TBD	TBD	TBD	60%	TBD
ACE/ARB usage	TBD	TBD	TBD	TBD	70%	TBD
Members referred to a smoking cessation program	TBD	TBD	TBD	TBD	80%	TBD

Achievement of Improvement:

- Not applicable at this time since this PIP is in the development phase.

Achievement of Sustained Improvement:

- Not applicable at this time since the PIP is in the development phase.

Overall Credibility of Results and Validation Findings:

- A determination regarding the overall credibility of the results was not made since this PIP is in the development phase.

Strengths:

- AHM selected a topic relevant to its membership where improving diabetic control of A1C levels could have a positive effect on controlling diabetic related complications of hypertension and hypercholesterolemia.
- AHM cited evidenced-based sources for topic rationale and developed comprehensive interventions directed towards providers and members.
- The PIP seeks active participation of providers and the Plan's Case Management & Disease Management staff and community resources to positively impact member outcomes for the control and prevention of diabetes, hypertension and hypercholesterolemia.

Opportunities for Improvement:

AHM did not directly state the study question – i.e., if the interventions will improve the outcome metrics. The stated focus of the PIP is secondary prevention to diminish short and long term effects of hypertention / hypercholesterolemia in the selected uncontrolled diabetes population.

- The PIP should clarify the outcome metrics in the PIP; specifically if controlled blood pressure is a metric. It is unclear which of the multiple conditions diabetes, hypertension and hypercholesterolemia have specific outcome metrics.
- The PIP should clarify the indicators that it is tracking in the study. It discusses multiple measures for tracking related to diabetes but also discusses a goal for increasing member blood pressure control rates.

Medical Card Systems (MCS) Medicare Performance Improvement Projects

The following narrative summarizes each of the two PIPs conducted by Medical Card Systems (MCS) that were in process during the contract year 2012-2013.

PIP #1: Beta Blockers Management in Patients after a Heart Attack

Study Topic Selection:
MCS provided a strong, evidence-based rationale for selecting beta blockers after heart attack as the study topic. MCS presented national, regional and plan-specific statistics in support of the topic including the prevalence of heart disease in the U.S., that heart disease is the leading cause of death in Puerto Rico, and HEDIS results indicating that MCS's rate for Beta Blockers after Heart Attack is below the 25th percentile. MCS determined that the study topic was relevant to their membership based on these data. MCS recognized practitioner variance from guidelines for treating post-MI patients with beta blocker therapy.

Study Question(s) and Indicator(s)
MCS did not identify a study question.

The indicator(s) for this QIP was HEDIS® Presence of Beta-Blockers Treatment after a Heart Attack. The numerator was members in the denominator who were dispensed ≥135 days' supply of beta blockers in the 180 days following discharge. Persistent treatment was defined as at least 75 percent of the days' supply dispensed.

The goal(s) or target(s) was to increase beta blocker use by a 5% increase over baseline for both SNP MCOs.

The objective(s) of the PIP was stated as "a secondary prevention project designed to reduce the incidence of subsequent heart attack, decrease need for interventional procedures such as angioplasty and bypass grafting, improve quality of life and extend overall survival in members who have suffered an acute myocardial infarction."

Study Population and Sampling:
The target population included all members ages 18 and older hospitalized and discharged after surviving a heart attack.

Exclusion criterion was members who had contraindications to beta-blockers therapy.

The baseline measurement period was 7/27/2009 – 9/10/2009.
The interim measurement period was CY 2010.
The final measurement period was CY 2011.

The baseline and remeasurement periods were not comparable.

The study methodology, data source(s) and sampling methods were not reported. However, since this was referenced as a HEDIS measure, those specifications would apply.

Data Collection Procedures:
The PIP did not identify the data sources and the methods used for data collection. However, this is a HEDIS measure that uses the administrative method.

Methods used to ensure validity and reliability was not reported, however, CMS requires that all HEDIS data be audited.

Interventions/Improvement Strategies:
The MCO identified the following provider barriers to improvement:

- Primary Care Physicians (PCPs) may not be aware which patients recently suffered a heart attack due to MCS's open model which allows direct access specialists without a PCP referral.

  MCS mitigated this barrier by developing a physician-focused strategy to send PCPs an alert notification for patients who have suffered a heart attack, have not filled a beta blocker prescription, and should be considered for beta blocker medication therapy.

- Physicians frequently changing their mailing address.
- Physician's resistance to changing patients' prescriptions.

  MCS partially mitigated these barriers by making additional efforts to update physicians' addresses and promotion of evidence based practice guidelines.

- Physician's using incorrect diagnosis codes.
- Members changing PCPs or disenrolling.

  Use of incorrect diagnosis codes and disenrollment of members were not addressed.

The interventions were as follows:

Year One and Two intervention:
PCP Alert: MCS's Pharmacy Department sent letters to physicians alerting them of patients who suffered a heart attack but did not fill a prescription for a beta blocker. MCS identified that surveillance and monitoring was more effective when conducted every 6 months. The intervention was implemented in 6/2011 and was ongoing every 6 months.

Member-focused interventions:

- No member-focused interventions were reported. MCS could have outreached members to remind them to fill their prescriptions for beta blockers and/or encourage them to see their PCP.

Health Plan-focused intervention

- No Health Plan-focused interventions were reported. MCS could have evaluated the open access model as a barrier to PCP patient management and care coordination.

Additionally, the following intervention(s) were planned going forward:

- MCS stated that making PCPs aware of the importance of notifying the MCO of address changes would be continued.

- MCS indicated that opportunities for improvement included are to revise the interventions and/or to deploy mitigation plans. However, MCS did not describe any specific intervention revisions planned or mitigation plan details.

Data Analysis and Results:
The reported results are presented in the table below.

Beta Blockers Management in Patients after a Heart Attack					
Indicator(s)	Year 1 Baseline Rate 7/27/2009 – 9/10/2009	Year 2 Interim Rate 2010	Year 3 Final Rate 2011	Target or Goal	Target or Goal Met?
Prevalence of Beta-Blocker Treatment After A Heart Attack (H4006)	58.27%	70.83%	78.61%	61.18%	Yes
Prevalence of Beta-Blocker Treatment After A Heart Attack (H5577)	71.34%	84.45%	85.94%	74.91%	Yes

It should be noted that in results table in the PIP report, the denominator for 2011 was shown as 162, when it was actually was 192.

Achievement of Improvement:
- MCO H4006 improved over baseline by 12.56 and 20.34 percentage points in 2010 & 2011, respectively. These results represented a 21.55% increase in 2010 and 34.91% increase in 2011. H4006 exceeded the goal of 61.18% in both remeasurement years.
- MCO H5577 improved over baseline by 13.11 & 14.60 percentage points in 2010 & 2011, respectively. These results represented an 18.38% increase in 2010 and 20.47% increase in 2011. H5577 exceeded the goal of 74.91% in both remeasurement years.

Achievement of Sustained Improvement:
- The intervention of alerting PCP's of members who had a heart attack was effective in achieving sustained improvement in rates for beta blocker usage among members post heart attack.
- There was a sustained improvement in beta blockage usage over a 2 year period.

Strengths:
- MCS selected a topic relevant to its membership and that could result in improved outcomes of a decrease in subsequent heart attacks and interventional cardiac procedures.
- The PIP targets a chronic condition where improvement should result in decreased costs, improved member survival rates and improved member quality of life.

Opportunities for Improvement:
- MCS did not directly state the study question – i.e., if the intervention will improve the outcome, in a question format.
- MCS should identify the data source(s) and the methodology used for data collection and calculating the indicator.
- MCS should implement a procedure to verify PCP addresses.

- MCS should track and report the number of successful provider alerts relative to the number of members eligible for an alert.
- MCS should track the number of inappropriate alerts issued due to coding errors.
- MCS might consider tracking the long term outcomes of the PIP by measuring and comparing subsequent heart attacks and interventional cardiac procedures following a heart attack for the population using beta blockers versus the population not using beta blockers following a heart attack.
- Since the remeasurement rates approach the HEDIS national mean, MCS should consider revising its goal as the HEDIS national mean or 75th percentile.

Validation Findings

- The validation findings generally indicate that the credibility of the PIP results is not at risk. Although HEDIS methodology was presumably used and the data were audited, results must be interpreted with some caution since the data source(s) and the data collection and indicator calculation methodologies were not specifically reported.

PIP #2: Osteoporosis Management in Women who had a fracture

Study Topic Selection:

MAA provided a strong, evidence-based rationale for the selecting the study topic. MAA presented national and plan-specific statistics in support of the topic including the prevalence of members who have been diagnosed with or are at risk for Osteoporosis, the percentage of the Plan's eligible members receiving Osteoporosis Management is below the national average and the fact that this condition is under-diagnosed and under-treated. MAA determined that the study was relevant to their membership due to the fact that a significant percentage of the Plan's membership are both under-diagnosed and are women 67 years of age & older who are at high risk for Osteoporosis. The Plan recognized this as an opportunity to reduce gaps and improve early Osteoporosis Screening or treatment among women.

Study Question(s) and Indicator(s)

MAA did not identify a study question.
The stated focus of the PIP is "a secondary prevention project designed to increase the amount of women that, after a fracture, had either a bone mineral density (BMD) test or prescription for drug to treat osteoporosis. These members have already experienced a fracture and are at risk for further fractures if the condition is not identified and remains untreated."

The indicator(s) for this QIP was/were stated as:

- OMW - Osteoporosis Management in Woman who had a Fracture.
- Numerator description: Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria: BMD test on the Index Episode Start Date (IESD), or in the 180-day (6 month) period after the IESD, or A BMD test during the inpatient stay for the fracture (applies only to fractures requiring hospitalization) or a dispensed prescription to treat osteoporosis on the IESD or in the 180-day (6 month) period after the IESD.
- Denominator description: MCS Classicare women 67 years and older as defined by HEDIS® Technical Specification 2011.
- Inclusion criteria: Women 67 years old and older, who suffered a fracture, as defined on HEDIS® Technical Specifications 2011.

The PIP's goal was to increase appropriate testing for or treatment of Osteoporosis by 2.5% above baseline per year for both contracts. The ultimate goal was a 5% increase above baseline at the end of the study for both contracts.

Study Population and Sampling:

The specifications for the indicator(s) were:
The target population was defined using HEDIS® methodology, includes all female members (women) ages 67 and older who suffered a fracture, and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

The inclusion criteria: Women 67 years old and older, who suffered a fracture, as defined on HEDIS® Technical Specifications 2011.

The baseline measurement period was 2012.
The interim measurement period was 2011.
The final measurement period was 2012.

The PIP did not identify if any sampling methods were used in the study.

Data Collection Procedures:
The PIP did not identify the data sources and the methodology used for data collection.

Interventions/Improvement Strategies:
The MCO identified the following barriers to improvement:

- Barriers identified included: Physician performance and care - lack of awareness regarding the silent phase of the condition, the importance of screening and/or treatment options prior and after a fracture, lack of confidence on treatment and liability, late transitional care communication and post discharge follow up by the PCP, late access to information about changes in member's health status, lack of awareness of evidence based practice guideline after a diagnosis, inappropriate management of treatment side effect. These barriers were mitigated by the interventions implemented by the Plan.
- Barriers identified included: Members' lack of awareness regarding prevention and early screening, lack of motivation and adherence to treatment and physician recommendations, cognitive and social barriers, and fear to treatment side effects. These barriers were mitigated by the interventions implemented by the Plan.
- Barriers identified included: lack of promotion of evidence-based practice guidelines among physicians, transitional care challenges regarding communication to PCP's and notification of member health status and a lack of partnership among service sectors. These barriers were mitigated by the interventions implemented by the Plan.

The interventions were as follows:

Provider-focused interventions:

- PCP/Primary Medical Groups Monitoring Reports on non-compliant members. The initiative included individual counseling to administrators and PCP's regarding the measure, and the non-compliant status of the member. Initiated in the 2nd Quarter 2011 and ongoing on a quarterly basis. On quarterly basis Primary Medical Groups impacted 28/42 (66%), total of PCP 1,809 / 3,411(53% of the participant providers). An average of 698 members identified as "not in compliance" were included in the report by PCP. The intervention was conducted by the Premium Management & Business Intelligence departments.
- PCP/Primary Medical Groups educational intervention - Development, distribution and individual counseling on HEDIS® Quick reference - Tabletop based on Evidence Based Practice Guidelines. Initiated in Dec 2011 and ongoing (frequency not indicated). As of February 2012, a total of 1,354 PCP (39.6% participant providers) received the counseling and the piece. The intervention was conducted by the Premium Management & Business Intelligence departments.
- PCP Education in Physician Congress - one on one counseling on HEDIS® measures including OMW, including distribution of related educational materials. Participated in 2 Conventions: February and May 2011. A total of 231 PCP received the one-on-one counseling representing 6.7% of providers. The intervention was conducted by the Premium Management department.
- PCP Training: HEDIS®/STARS 101 training. Education on HEDIS® Measures including OMW to PCP. Completed during the 3rd & 4th quarter (did not identify time period as 2011 or 2012). A total of 361 participants including PCP's, PMG Administrators and Staff. The intervention was conducted by the Premium Management department.

- Education to PCP/PMG Presentation of CHRA medical record tool included areas for HEDIS® measure OMW. Initiated Jan 2011 and ongoing for a 9 month period. A total of 262 participants including PCP and PMG Administrators. The intervention was conducted by the Premium Management department.
- Evaluation, Adoption, Development and Dissemination of a Quick reference of the National Osteoporosis foundation Clinical Practice Guidelines for the Management of Osteoporosis. Adopted July 28, 2011; Notification to Providers: September 27, 2011; Development of Quick Reference Q4 2011 Distribution -Q1-Q2 2012 on an ongoing basis. Notification of Adopted Evidence Based Practice Guideline was mailed to 5,470 Providers - 100% of the Provider Network including specialists. The intervention was conducted by the Education and Wellness Unit / Clinical Affairs departments

Member-focused interventions:

- Primary Prevention: Provided group educational interventions about related topics: Bone Health and Osteoporosis Screening. Member interventions were included in the Program Calendar and sent to 100% of Classicare membership in both contracts on a bi-monthly basis. Initiated January 2011 and distributed periodically (frequency not indicated). Targeted the general MCS Classicare Population under both contracts. 2011 results: A total of 10 sessions offered: 1,000 Members (1% of the entire Classicare population). Conducted by the Education and Wellness Unit / Clinical Affairs, Business Intelligence Unit, Quality Department.
- Preventive reminders by mail: women identified as non-compliant with screening testing or treatment after the fracture. The Q1-Q2 initiative was on monthly basis tied to the member birthday. Initiated January 2011 and distributed from Jan-Jun 2011 on a monthly basis on the member's birthday. Targeted the general MCS Classicare = Identified "without" fracture diagnosis a total of 891 reminders were sent to 100% of the identified / target population. Conducted by Education and Wellness Unit / Clinical Affairs, Business Intelligence Unit, Quality Department.
- Preventive reminder by mail to women identified as not having a BMD test or treatment for Osteoporosis after a fracture, as defined by HEDIS®. Identification based on utilization reports as of Nov. 2011. The letter recommended the member visit their PCP to discuss the information received and receive the screening. In addition to the letter, an educational piece was included for reference describing the preventive measure importance and the recommendations. PCP's were informed of the strategy and the recommendations. Initiated November 2011 and ongoing on a quarterly basis. Target population: 67 years old or more women that as of November 2011 were identified not in compliance with the BMD test or treatment after the fracture. In November, a letter was sent to a total of 977 women from both contracts identified representing 100% of the target population. Conducted by the Education and Wellness Unit / Clinical Affairs, Business Intelligence Unit, Quality Department.
- Member newsletter included articles of related topics in Volume 2. A first article was included about the importance of preventive measure including BMD test. In Volume 3, a second article about Osteoporosis, risk factors and screening was included. Initiated in May 2011 and September 2011 on a quarterly basis. Targeted the general MA and SNP population under both contracts. Newsletter was sent to 100% of MA members and 100% Platino members. The intervention was conducted by the Education and Wellness Unit / Clinical Affairs departments.
- Preventive reminder via IVR to non-compliant members. Initiated 2nd quarter 2012 and ongoing. Target population 67 year old or older woman admitted with a fracture. The intervention was conducted by the Education and Wellness Unit.

- Promote easy access to test, by including the BMD in Wellness outreach activities to members. Individual calls to members to inform about the need of test and the invitation to the wellness activity. Initiated 2nd quarter 2013 for a 4 month period. Target population 67 year old or older woman admitted with a fracture. The intervention was conducted by the Education and Wellness Unit and Premium Management Department.
- Coordination of home visits to perform BMD for members reporting barriers to getting the test. Test results are shared with member's PCP to assure continuity of care. Initiated 3rd quarter 2013 for a 6 month period. Target population 67 year old or older woman admitted with a fracture. The intervention was conducted by the Premium Management department.

Health Plan-focused intervention:

- Identify member after a fracture: health plan utilization hospitals reviewers will early identify members with fracture and provide recommendations to the MD managing the admission. Initiated 2nd quarter 2012 and ongoing. Target population 67 year old or older woman admitted with a fracture. The intervention was conducted by the Hospital Utilization Review Unit and the Education and Wellness Unit.

Additionally, the following intervention(s) were planned going forward:

- Reducing communication gaps related to changes in the Plan's member health status as well as the availability of monitoring reports early after a member's condition changes and experiences a fracture.

Data Analysis and Results:

The reported results are presented in the table below.

MCS PIP 2009-2011 Osteoporosis Management in Women who had a fracture					
Indicator(s)	**Baseline Rate 2010**	**Interim Rate 2011**	**Final Rate 2012**	**Target or Goal**	**Target or Goal Met?**
OMW Osteoporosis Management in women who had a fracture (contract H5577)	11.36%	15.72%	16.77%	16.36%	Yes
OMW Osteoporosis Management in women who had a fracture (contract H4006)	16.94%	19.62%	19.87%	21.94%	No

MAA's goal was to increase appropriate testing for or treatment of Osteoporosis by 2.5 percentage points above baseline per year for both contracts. The ultimate goal was a 5 percentage point increase above baseline at the end of the study for both contracts. The study consisted of a baseline year (2010) and two re-measurement periods (2011-2012). (**Note: The goal rate for contract H4006 is shown as 21.64% – it should be 21.94%; the re-measurement rates for 2011 should be 19.62, not 19.82, and 15.72, not 15.61 for H4006 and H 5577, respectively, based on the numerators and denominators reported.)** Over the course of the study, both contracts showed sustained improvement compared to the baseline year but the rate of improvement in re-measurement year 2 was not as pronounced as in re-measurement year 1. It is reasonable to state that the cumulative effect of the multiple interventions implemented in the study had a positive effect on the study's indicator results.

Achievement of Improvement:

- Contract H5577 improved by 4.36 percentage points from baseline year 2010 to re-measurement year 2011 which exceeded the yearly goal of a 2.5 percentage point increase. H5577 improved by 1.05 percentage points from 2011 to re-measurement year 2012 which did not exceed the yearly goal of a 2.5 percentage points increase; the final rate increase of 5.41 percentage points did exceed the goal of a 5% increase over the 2010-2012 timeframe.
- Contract H4006 improved by 2.68 percentage points from baseline year 2010 to re-measurement year 2011 which exceeded the yearly goal of a 2.5 percentage point increase. H4006 improved by 0.25 percentage points from 2011 to re-measurement year 2012 which did not exceed the yearly goal of a 2.5 percentage point increase. Also, the Plan did not exceed the goal of a 5% increase over the 2010-2012 timeframe.

Strengths:

- MAA selected a topic relevant to its membership where increased screening and treatment of Osteoporosis following a fracture could decrease the reoccurrence of further fractures. This could lead to decreased costs, increased detection and\or prevention of Osteoporosis and improved member functionality & quality of life.
- The plan cited evidenced-based sources for topic rationale and implemented multi-faceted provider, member and health plan interventions.
- The study resulted in sustained improvement of Osteoporosis management rates over a 2 year period for both contracts.

Opportunities for Improvement:

- MAA did not directly state the study question – i.e., if the intervention will improve the outcome, in a question format.
- The Plan should identify the data source used in the PIP and the methodology used for collecting data & calculating the data results.
- There are reporting errors in the data table presented in the PIP. Improved accuracy of reporting results provides the Plan the opportunity to present results accurately and not subject them to interpretation.

Overall Credibility of Results and Validation Findings:

There are one or more validation findings that indicate a bias in the PIP results. The results must be interpreted with caution due to fact that the PIP did not identify the data source, the methodology for collecting & calculating the data and there are discrepancies in reported data results & goal rates.

PIP # 3: Reducing Plan All-Cause Hospital Readmissions

Study Topic Selection:

MCS provided a strong rationale for topic selection. The rationale included MCO-specific and national statistics and information regarding hospital readmissions within 30 days of discharge.

The following were cited:

- The New England Journal of Medicine article that reported national readmission rates of 20% with an annual cost of $17 billion (2009).
- Heart failure ranked as one of the top 5 diagnoses associated with readmission and systemic factors (members, providers, health system) that impact readmission.
- Frequent readmissions for the elderly with multiple co-morbid conditions associated with inadequate follow-up post discharge.
- Risk factors for readmissions including fragmentation of care which contributes to medical error, service duplication, and lack of post-discharge follow-up.
- MCO-specific SNP population data for the HEDIS 2013 (MY 2012) All Cause Readmission Rate of 12%. The CY 2012 rate was lower than the CY 2011 rate of 17.10% but is an opportunity for improvement as it is substantially higher that the external benchmark CMS/Medicare 2012 Five Star Rating threshold of less than or equal to 5%.
- MCS cited the Chronic Care Model that focuses on four elements: Self-management Support; Delivery System Design; Decision Support; and Clinical Information Systems which resulted in significant reductions in readmission rates

The project aligns with the Health & Human services (HHS) initiative- Partnership for Patients goals, to decrease preventable complications during transitions in care settings and reduce hospital readmissions.

Study Question(s) and Indicator(s)

MCS did not define a specific study question for this project.

The indicator(s) for this QIP was based on the HEDIS All-Cause Readmission measure. Four denominators were defined as specified in CMS Technical Notes:

- Hospitalized members active in a Complex CM regardless of diagnosis;
- Hospitalized members not active in a Complex CM with a diagnosis of Heart Failure;
- Hospitalized members not active in a Complex CM regardless of diagnosis; and
- Hospitalized members 65 years of age and older

Planned process measures included:

- Percent of members referred to the CCM program enrolled.
- Percent of members participating in CCM program with a completed readmission prevention assessment.
- Percent of members participating in the CCM program who had a home visit by a Community Outreach Technician.
- Percent of care plan interventions completed during CCM program participation.
- Percent of members participating in the program with at least 4 follow-up visits within 30 days.
- Percent of members referred to another care program.
- Percent of members evaluated by the care manager as medically unstable and unable to access an outpatient facility who had a physician home visit during the 30 days post-discharge.

The goal or target was to achieve at least a 25% change in the total number of members with readmissions after 30 days participating in the program, and to decrease all-cause 30-day readmission rate by at least 4.5 percentage points at the end of the 3-year project (i.e., 1.5 percent per year).

The objective was stated as reducing all-cause 30-day readmission rates by decreasing preventable readmissions for:

- Members active in a Complex Care Management (CCM) program regardless of diagnosis Members not active in a CCM program with a diagnosis of Heart Failure
- Members not active in a CCM program regardless of diagnosis
- Members ages 65 years and older

MCS specified a decrease of 4.5 percentage points over 3 years, the decrease per year was misstated as 1.5 percent per year. This should have been written as 1.5 percentage points per year. Also, MCS referenced the readmission rate of ≤ 5% to align with the Medicare Stars Quality Five Star rating threshold. The goal(s) should have included achieving an All Cause Readmission Rate of≤ 5% in addition to or rather than a percentage point decrease in the rate. In addition to the overall goal, separate target rates should have been established for each of the four populations, with supporting rationale provided for each.

Study Population and Sampling:

MCS indicated that the HEDIS All Cause Readmission measure would be used for this PIP. The measure specifications define the eligible population/sample.

The target populations were further defined as hospitalized members active in a CCM program regardless of diagnosis or readmission status; hospitalized members not active in a CCM program with a diagnosis of Heart Failure, regardless of readmission status; and hospitalized members not active in a CCM program for whom admission represents a readmission regardless of diagnosis from hospital admission/discharge census submitted to the MCS registry, in concurrent inpatient review and/or have service coordination upon discharge.

MCS indicated that the population to be referred to the program was derived from eligible members from the admission/discharge census registry identified by nurses conducting concurrent inpatient Utilization Review; nurses that coordinate discharge services related to inpatient discharge. Eligible members active in a CCM program were identified by the Care Management designee.

The specification “regardless of readmission status” was not appropriate. The outcome measure quantifies the rate of readmission; all members with and without a readmission are included in the denominator and the numerator is defined as those with a readmission. Each of these measures should be defined by specification of the numerator and denominator for each; each denominator should also specify the appropriate age group, as in the HEDIS measure.

The specific numerators and denominators for each of study indicators and the process measures were not defined.

The baseline measurement period was CY 2012 (reported 2013).
The interim measurement period will be CY 2013 (reported 2014).
The final measurement period will be CY 2014 (reported 2015).

The PIP reported the following timeframes for data collection and reporting: "The first year of the intervention will be January 1, 2014 to December 31, 2016." This represents two years, so needs to be corrected in the report. The PIP continues, "The second year and the third year will run the same." Again, correct timeframes for data collection and reporting need specification in the report.

The data source(s) were not specifically described. Presumably, inpatient claims/encounter data will be used, at a minimum.

MCS reported that there would be no sampling.

Data Collection Procedures:

The reported data sources for the study indicator(s) included claims (medical, pharmacy, and laboratory) and HEDIS. The data sources for the process measures data was McKesson's CareEnhance Clinical Management Software (CCMS), MCS's medical management documentation system for pre-authorization, concurrent review, and care management.

Data collection procedures were not reported for the HEDIS All-Cause Readmission measure other than a statement that "MCS collects and reports HEDIS data for Medicare, including patient-level data as required by CMS" and "Data are reported in the following categories: Count of Index Hospital Stays (denominator), Count of 30-Day Readmissions (numerator).

Based on this, it appears that data reporting is limited to the All Cause Readmissions rate. If so, MCS evaluate the feasibility of reporting the indicators for the four sub-populations described. MCS might consider additional outcome measures for the subpopulation with an index stay principal diagnosis of heart failure: all-cause 30-day readmissions and cause-specific 30-day readmissions with a principal diagnosis of heart failure.

Methods used to ensure validity and reliability was not reported, though CMS requires that HEDIS data be audited.

Interventions/Improvement Strategies:

MCS identified the following anticipated member barriers to Care Plan development and care coordination:

- Lack of member engagement in the CCM program
- Lack of acceptance of Care Manager follow-up and education
- Lack of member support system

MCS indicated that the barriers would be mitigated by:

- Assistance from the Community Outreach Program
- Training CM nurses in motivational interviewing techniques
- Identification of additional community resources and support systems by the Community Outreach Technician.

MCS identified the following anticipated member and provider barriers to the physician home visit:

- Lack of members' acceptance of home visitation.
- Lack of communication from home visit physician with rest of interdisciplinary health care team.

MCS indicated that the barriers would be mitigated by:

- Training CM nurses in motivational interviewing techniques and teach back method.

- Promoting provider engagement with the initiative by delivering provider education about the program.

The interventions were as follows:

Provider-focused interventions:
No provider-focused interventions were reported.
MCS should have included the stated mitigation plans (e.g., training CM nurses on motivational techniques, provider education) as provider focused interventions. In addition, MCS could have initiated a process for arranging follow-up visit appointments prior to discharge.

Member-focused interventions:
- Care Managers conduct telephonic readmission prevention assessments of members enrolled in the CCM program.
- Care Managers establish a care plan and begin coordination to achieve goals.
- Care Manager will coordinate a physician home visit if needed.

Health Plan-focused interventions:
No Health Plan-focused interventions were reported. MCS could have placed UR staff onsite in the hospitals to proactively identify members pending discharge and in need of follow-up plans.

Data Analysis and Results:
The reported results are presented in the table below.

Improving Post Discharge Care Coordination from Hospital (PDCC)					
Indicator(s)	**Year 1 Baseline Rate CY 2012**	**Year 2 Interim Rate CY 2013**	**Year 3 Final Rate CY 2014**	**Target or Goal**	**Target or Goal Met?**
% of members aged 65 years and older readmitted to the hospital within 30 days of discharge with any diagnosis	12.20%	Pending data	Pending data	7.7%	Pending
% of members aged 65 years and older with an index stay principal diagnosis of heart failure readmitted to the hospital within 30 days of discharge with any principal diagnosis	27.5%	Pending data	Pending data	Not defined	NA
% of members aged 65 years and older with an index stay diagnosis of heart failure readmitted to the hospital within 30 days of discharge with a principal readmission diagnosis of heart failure	10.5%	Pending data	Pending data	Not defined	NA

Additional baseline data reported for the baseline measurement (CY 2012) were as follows:
- Heart failure comprised 6% of hospitalizations (484/7825)
- Among index stay hospitalization for heart failure, the all cause readmission rate was 27.5% and the cause-specific readmission rate for heart failure was 10.5%

- Of the 7,825 readmissions, 1,312 readmissions "were related to other diagnoses" (i.e., all-cause readmissions). There was an error in calculation. A rate of 16.77% is obtained when dividing 1,312 by 7825, but MCS reported an all-cause readmission rate of 91%.
- The HEDIS 2012 (MY 2011) PCR rate for the MCO H5577 was 12.40% and the HEDIS 2013 (MY 2012) rate was 12.20%.

MCS used a variety of abbreviations in reporting these measures. Abbreviated terms should be spelled out the first time used and defined.

Achievement of Improvement:
Since interim measurement data are pending, achievement of improvement cannot be assessed.

Achievement of Sustained Improvement:
Achievement of sustained improvement will be evaluated when the 2015 rates are reported and compared to the baseline and interim rates.

Strengths:
- MCS selected a topic relevant to its membership and for which evidence-based interventions could result in reducing hospital readmissions, improving member overall health and increasing member satisfaction.
- The PIP targeted hospital readmissions which can decrease potentially preventable costs and result in better health outcomes through promoting access to preventive care.
- MCS developed process measures to assess the effectiveness of the interventions.
- MCS developed a comprehensive process for assessing members' risk for hospital readmission.
- MCS utilized the CCM program to focus on members with special healthcare needs who are at higher risk for readmission.
- MCS utilized home visits by providers for post-discharge follow-up in an effort to prevent avoidable readmissions.

Opportunities for Improvement:
- MCS should define a specific study question for this project.
- MCS might consider the following outcome measures for members with an index stay with a principal diagnosis of heart failure: an all-cause readmission indicator for this subpopulation and a cause-specific indicator for readmission with principal diagnosis of heart failure.
- MCS should clearly define the indicators, specifying the denominators and numerators for each of the study indicators and process measures.
- MCS should fully describe the study methodology, including the data source(s) and methods used for data collection, ensuring reliability and validity and calculating rates.
- MCS should revise its goals to align with the stated benchmark, the Medicare Stars Quality Five Star rating threshold for All-Cause Readmissions and revise the rationale accordingly.
- MCS should add interventions that target providers and hospitals, such as those mentioned in the plan to mitigate provider barriers.
- MCS should consider developing Health Plan-focused intervention(s).
- MCS should specify the timeframes for the interventions and consider interventions that could be initiated prior to discharge.
- MCS should report and track the stated process measures in order to evaluate the reach and effectiveness of the interventions, including the denominators, numerators and percentages.

- MCS should ensure that data in the results tables are clearly labeled so that data are not misinterpreted.
- MCS should address the use of abbreviations. Abbreviated terms should be spelled out the first time used and defined.

Validation Findings:

The credibility of the PIP results cannot be evaluated at this time due to the pending remeasurement data. However, the methodological issues cited should be addressed prior to the next report.

MMM/PMC Medicare Performance Improvement Projects

The following narrative summarizes each of the two PIPs conducted by MMM/PMC that were in process during 2012-2013.

MMM PIP #1: Reducing All Cause Readmissions through the Improvement of Medication Review Compliance

Study Topic Selection:
MMM provided an evidence-based rationale for the selecting the study topic. The MCO presented national, regional and plan-specific statistics in support of the topic. The following were cited: the frequency of all-cause hospital readmissions, the provider compliance rates for medication reviews, the provider compliance rates for recording polypharmacy among the elderly, the impact of drug interactions on emergency room visit rates, and rates for adverse drug events among hospitalized patients.

MMM demonstrated relevance to the MCO's membership by reporting an overall hospital readmission rate of 12.33% and a rate of 12.47 % rate among dual-eligible members. Both rates exceed the national benchmark of ≤ 5% based on the CMS Five Star Rating Technical Notes. In addition, MMM's rate for provider compliance with medication review of 53.04% falls well below the national benchmark of 90.5%.

Study Question(s) and Indicator(s)
MMM did not identify a study question.

The indicator was defined as the HEDIS Medication Reconciliation Post-Discharge measure, the percentage of Medicare Advantage Special Needs Plan enrollees ages 66 years and older (denominator) who received at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year with the presence of a medication list in the medical record (numerator).

The stated goal was to improve medication review compliance by achieving the 90th percentile of compliance by 2015. The target was to increase the provider medication review compliance rate from 53.04% (current rate) to 95% in 2015.

The following goal was also reported: reduce the readmission rate for the eligible population from 12.47% (current rate) to 8%. Although not listed in the indicators, the report indicated that this goal would be measured via HEDIS Plan All-Cause Readmission rate for the HEDIS 2012, 2013 and 2014 time periods. The benchmark source was stated as NCQA Medicare HEDIS 2011 Audit, Means, Percentiles and Ratios for Medicare, though a percentile goal was not stated.

The stated objective of the PIP was to improve provider compliance with the medication review process and improve member awareness of the importance of medication knowledge, although the PIP title indicated that reducing readmission rates was the objective.

Study Population and Sampling:
The study population was not specifically identified except as dual eligible Medicare Advantage Special Needs Plan enrollees 66 years and older.

The denominator was stated as the percentage of Medicare Advantage Special Needs Plan enrollees ages 66 years and older.

The numerator was defined as those who received at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year with the presence of a medication list in the medical record.

No other criteria were reported, but presumably, the members must have had an inpatient admission so that readmissions could be addressed.

The baseline measurement period was CY 2012.
The interim measurement period will be CY 2013.
The final measurement period will be CY 2014.

A sampling method was not described, though it is presumed that sampling, if any, was conducted according to HEDIS methodology.

Data Collection Procedures:
The specific data source(s) and the method(s) used for data collection were not provided. However, HEDIS 2012 was reported as a data source and the HEDIS measures Plan All-Cause Readmission and Medication Reconciliation Post-Discharge rates were named, so it is presumed that HEDIS specifications and methodology were used.

Methods used to ensure validity and reliability was not reported, however, CMS requires that HEDIS data be audited.

Interventions/Improvement Strategies:
Member barriers identified included:

- The mobile health assessment event reaching/impacting a low percentage of eligible members compared to the overall large number of eligible members. MMM indicated that this would be mitigated by using alternate interventions such as distribution of information through member portals and newsletters.
- Members not attending the PREVENTOUR mobile health assessment event due to inability to reach the member, member declining the invitation, or lack of transportation. MMM planned to mitigate these barriers by using alternate invitation strategies such as placing promotional posters and flyers in medical offices and MMM Regional Offices and sending educational materials via mail.
- Member non-compliance with PCP appointments for completion of health assessments.

Provider barriers identified included:

- PCPs not completing annual assessments within the established timeframe.

The interventions were as follows:

Provider-focused intervention(s):

- Instruct PCPs to complete Annual Health Assessments, including medication review, on paper or electronically through InnovaMD (the provider portal). Data collected will be audited and used as supplemental data for HEDIS data collection.
- Share Medication Review data collected via the PREVENTOUR mobile health assessment event with PCPs with recommendations for follow-up.
- The timeframe for the intervention is from January 1st to June 30th of the respective year.

- MMM did not describe how PCPs were to be introduced to and trained to complete the Annual Health Assessment/medication reviews. Additionally, working with hospital facilities on a pre-discharge medication reconciliation initiative would enhance the intervention strategy.

Member-focused interventions:

- Conduct an Awareness Campaign for eligible members not compliant with the HEDIS Medication Reconciliation Post-Discharge measure and non-adherent with three (3) or more maintenance medications. The Awareness Campaign will support the completion of the Annual Health Assessment at which Medication Review data will be collected and submitted as supplemental data to HEDIS data collection process.
- Educate members on recommendations for after hospital discharge via posters and flyers in PCP offices and mass media (newspaper, radio, TV).
- The timeframe for the intervention will be on a year to year basis.

Health Plan-focused intervention:

- Conduct Medication Review through the PREVENTOUR mobile healthcare unit. The target population will be members not in non-compliance with the HEDIS Medication Reconciliation Post-Discharge measure and non-adherent with three (3) or more maintenance medications. The Medication Review will be completed by a clinical pharmacist and documented in the InnovaMD system. The results of the assessment and recommendations will be sent to the member's PCP electronically for follow-up. The member data collected via the mobile healthcare unit initiative will used as supplemental data for the HEDIS data collection.
- The timeframe for the intervention will be on a year to year basis.

Data Analysis and Results:

The reported results are presented in the table below.

MMM Healthcare Reducing All Cause Readmissions through the Improvement of Medication Review measure					
Indicator(s)	**Baseline Rate CY 2012**	**Interim Rate CY 2013**	**Final Rate CY 2014**	**Target or Goal**	**Target or Goal Met?**
Provider compliance with medication review (HEDIS Medication Reconciliation Post-Discharge)	TBD	TBD	TBD	95%	TBD
HEDIS All-Cause Readmission Rate	TBD	TBD	TBD	8%	TBD

No results were reported as no measurements were conducted. The project was in the development phase.

Achievement of Improvement:

- Not applicable at this time as data are pending. The PIP was in the development phase.

Achievement of Sustained Improvement:

- Not applicable at this time as data are pending. The PIP was in the development phase.

Strengths:

- MMM selected a topic relevant to its membership that could potentially improve member-PCP communication and engagement, increase the accuracy of member's medication lists, decrease medication errors and adverse drug interactions, diminish complications due to drug interactions and result in fewer preventable hospitalizations and readmissions.
- The project rationale was evidenced-based.
- MMM planned interventions directed towards the health-plan, providers and members.
- The interventions seek active participation of providers, pharmacists, and members in order to impact medication review compliance rates.
- MMM developed mitigation plans to address the identified and increase the intervention effectiveness.

Opportunities for Improvement:

- MMM did not directly state the study question – i.e., if the interventions will improve the outcome of reducing all cause readmissions, in a question format.
- MMM should clarify the PIP objective(s): to improve provider compliance with medication review and/or reducing readmission rates.
- MMM did not directly state that the HEDIS All-Cause Readmission was an indicator although the PIP title references this.
- MMM should clarify the study population, the indicator, denominators, numerators, the data sources and the methodology used for collecting data and calculating the rates.
- MMM did not describe how PCPs were to be introduced to and trained to complete the Annual Health Assessment/medication reviews.
- MMM should strongly consider working with hospital facilities on a pre-discharge medication reconciliation intervention.
- MMM should include process measures for tracking member participation in the medication review and the effectiveness of members outreach interventions.

Overall Credibility of Results:

- The credibility of the PIP results cannot be evaluated at this time due to the pending remeasurement data. However, the methodological issues cited should be addressed prior to the next report.

PMC PIP#1: Reducing All-Cause Hospital Readmissions through Improving Medication Review

Study Topic Selection:
PMC supported its topic selection with the statement that a review of the literature shows concurrence that the main cause for hospital readmission is a lack of communication between the patient and doctor and practitioner non compliance with medication review process; however, PMC did not cite or provide references for the scientific literature that supports the link between medication review and prevention of hospital readmissions.

The rationale included MCO-specific and national statistics. PMC reported MCO-specific data for the Medicare HEDIS Medication Reconciliation Post-Discharge measure and All-Cause Readmission rates.

The following were included in the rationale for the topic selection:

- PMC stated that, according to the World Health Organization, between 65% and 90% of the elderly population takes some type of medication.
- PMC cited a 2010 Puerto Rico Health Department report that indicated more than half of the elderly population (52.1%) takes more than three medications per health condition, which presents a risk of drug interaction. No supporting evidence was provided.
- PMC cited the National Academies of Science report "Identifying and Preventing Medication Errors" finding that drug interactions account for almost 4% of all emergency room visits and approximately one-third of adverse drug events in hospitalized patients.
- The rationale stated that there is an increasing body of published evidence supporting the effectiveness of medication review as a means of reducing medicine-related problems in the elderly population, optimizing therapy, improving health outcomes and cutting waste; that evidence is emerging that shows targeted medication review can enable people to maintain their independence and avoid admission to residential care or hospitals; and, some studies show that community pharmacists are being encouraged to increase their participation in patient-focused services such as medication reviews. PMC did not cite or reference any studies supporting these statements.
- PMC reported MCO-specific data: HEDIS 2013 (MY 2012) All Cause Readmission rate of 13% (PMC Medicare Choice) and 14%, (PMC Dual Eligible Choice) which represented an opportunity for improvement when compared to the external benchmark, CMS/Medicare 2012 Five Star Rating threshold of ≤ 5%.
- This project aligns with the Health & Human services (HHS) initiative Partnership for Patients goal to decrease preventable complications during transitions from one care setting to another to reduce hospital readmissions.

PMC did not provide an evidence-based rationale to link medication review to reducing hospital readmissions.

Study Question(s) and Indicator(s):
PMC did not define a specific study question for this project.

The indicators were reported as:

- HEDIS Medication Reconciliation Post-Discharge measure
- HEDIS Plan All-Cause Readmission measure

PMC described the goals and objectives of the PIP as follows:

- Improving compliance with the HEDIS Medication Reconciliation Post-Discharge measure for PMC dual-eligible members by achieving the 90th percentile by 2015.
- Increasing the rate for dual-eligible population from 39.17% to a 95% compliance rate by 2015.
- Reducing the HEDIS All Cause Readmission rate for PMC dual-eligible members from 14% to 8%.

The source of the benchmark was described as the Medicare HEDIS 2011 Audit, Means, Percentiles and Ratios benchmark of 90.5% among the healthcare industry. PMC should clarify whether the target rate is 95% or 90.5% compliance.

Study Population and Sampling:

The specifications for the indicator(s) were not described, the denominators were not defined, the numerators were not defined, and the sampling method(s), if any, were not described; however, the HEDIS measures were referenced. Since the HEDIS measures were used as indicators, it is presumed HEDIS specifications and methodology was followed.

The Risk Assessment table does describe the target audience for the interventions as:

1. For the medication review intervention: PMC dual-eligible members non-compliant with the Medication Reconciliation Post-Discharge measure, e.g., non-adherent with 3 or more maintenance medications.
   This is not consistent with the state study population and the method to identify non-adherent members is not described.
2. For the Annual Health Assessment intervention: PMC dual-eligible members non-compliant with the annual health assessment.
   This is not consistent with the stated study population and the method to identify non-adherent members is not described.
3. For the Awareness Campaign intervention: PMC dual-eligible members non-compliant with the Medication Review measure.
   This is not consistent with the stated study population and the method to identify non-adherent members is not described

PMC should report the specific measure descriptions, including criteria for eligible population, denominator and numerator.

PMC did not report any process measures to monitor the implementation and assess the effectiveness of interventions.

The baseline measurement period was CY 2012
The interim measurement period will be CY 2013
The final measurement period will be CY 2014

Data Collection Procedures:

Reported data sources included claims (medical, pharmacy, and laboratory) and HEDIS data.
The data collection method(s) and method(s) used to ensure validity and reliability were not reported. However, CMS requires that all HEDIS data be audited.

PMC should report the data collection method and efforts to ensure reliability and validity of the data.

Interventions/Improvement Strategies:
The interventions were as follows:

Provider-focused interventions:

- Communicate the results and recommendations from the mobile medication review to the members' PCPs through the InnovaMD application (provider portal).
- Develop and implement a new Annual Health Assessment format that includes medication review measures to assist PCPs in identifying therapeutic duplication, under-use, over-use or drug interactions.
- PMC stated the data collected through the Annual Health Assessments will be audited and used as supplemental data for HEDIS data collection.

PMC did not describe how these interventions would be introduced and implemented with providers. In addition, PMC should pursue a medication reconciliation initiative with hospitals to address this issue prior to discharge.

Member-focused interventions:

- Conduct Medication Review via the mobile healthcare unit (PREVENTOUR). Eligible members will be invited via telephone to participate in medication review and one-on-one medication use education conducted by a clinical pharmacist.
- Conduct a member Awareness Campaign to reach members who are non- compliant, including educational posters and flyers on "what to do after a hospitalization" in PCP offices and via mass media (newspaper, radio, TV).

Data Analysis and Results:

The reported results are displayed in the table below.

PMC PIP Reporting Period 2014-2016: Reducing All Cause Readmissions through improving Medication Review					
Indicator(s)	**Baseline Rate (HEDIS 2013) 2012**	**Interim Rate (HEDIS 2014) Y1 - 2013**	**Final Rate (HEDIS 2015) Y2 - 2014**	**Target or Goal**	**Target or Goal Met?**
HEDIS Medication Review Measure	39.17%	TBD	TBD	95%	Pending results/data
HEDIS All Cause Readmission Measure	14%	TBD	TBD	8%	Pending results/data

Achievement of Sustained Improvement:

Strengths:

- The PIP targets hospital readmissions as an outcome for improvement, as well as medication review as a means to reduce hospital readmissions; taken together, potential improvements may result in better health outcomes for members.

Opportunities for Improvement:

- PMC should strengthen the study rationale by citing and referencing evidence-based findings regarding how improving medication adherence can reduce the risk of hospital readmissions.
- PMC should state a specific study question.
- PMC should specify the numerator and denominator for each outcome and process measure.
- PMC should clarify the PIP goals/benchmarks.
- PMC should use process measures to identify barriers and develop mitigation plans using the reported anticipated barriers.
- PMC should develop process measures designed to track the implementation and assess the success of each intervention.
- PMC should describe how the annual assessment and medication review efforts will be implemented for providers.
- PMC should develop specific provider-targeted interventions, such as education efforts and distribution of gap reports to identify non-compliant members and to track changes in compliance.
- PMC should implement and initiative with hospitals to address pre-discharge medication reconciliation.
- PMC should develop health-plan focused interventions, such as production of gap reports.

Validation Findings

The credibility of the PIP results cannot be evaluated at this time due to the pending remeasurement data. However, the methodological issues cited should be addressed prior to the next report.

Triple S Medicare Performance Improvement Projects

The following narrative summarizes each of the three PIPs conducted by Triple S that were in process during 2012-2013.

PIP #1: Reducing Hospital Readmissions for Congestive Heart Failure

Study Topic Selection:
Triple S provided an evidence-based rationale for the study topic. TSS presented national and plan specific statistics in support of the topic including the prevalence of congestive heart failure, the rates of congestive heart failure (CHF) admissions & readmissions, and the rate of CHF mortality, as well as CHF hospitalization costs.

TSS supported the relevance to its membership by citing that CHF is among the top five diagnoses for the MCO-specific all-cause admissions. The MCO's all-cause readmission rate is 14.04%, however, it is not clear from the statistics presented whether CHF readmissions account for a significant percentage of all-cause readmissions. TSS reported that CHF admission costs exceed $4 million dollars annually.

Study Question(s) and Indicator(s):
TSS did not identify a study question.

The PIP's study indicator was based on the HEDIS® All-cause Readmission measure, modified to address only members with a diagnosis of CHF: Members with an index admisssion discharge diagnosis of CHF (ICD9: 428-428.09) who presented with a readmission (not 428.X diagnosis specific) within a 30 day period from the indexed discharge.

The stated objective of the PIP was to measure the 30-day readmission rates for TSS members with a CHF discharge diagnosis for the index admission to determine the impact of a discharge transition intervention.

The goal of the PIP was to reduce the CHF readmission rate by 20% over a 3 year period (a 10% reduction in re-measurement year 1, and an additional 5% reduction annually in re-measurement years 2 & 3). TSS did not indicate a goal/benchmark rate for the CHF member readmissions, since the PIP is in the development phase.

Study Population and Sampling:
The study population was stated as all eligible members with a registered acute hospital admission during the measurement year. The MCO estimated that 623 members will be affected by the project.

The denominator was defined as members with an index admission discharge diagnosis of CHF (ICD9: 428-428.09).

The numerator was defined as the number of members with an index admisssion discharge diagnosis of CHF (ICD9: 428-428.09) who presented with a readmission (not 428.X specific) within a 30 day period from the indexed discharge.

Exclusions were defined as any admissions not registered; admissions to a Skilled Nursing Facility (SNF) or rehabilitation facility; admissions for pregnancy, childbirth, and puerperium; admissions with ESRD (585.6) as a primary diagnosis; admissions with cancer (140-239) as a primary diagnosis; and admissions with cirrhosis of the liver (571.5) as a primary diagnosis.

Sampling was not performed.

Data Collection Procedures:

Triple S reported that data were to be collected from registered admissions and administrative claims data for pharmacy and Emergency Room visits.

Methods used to ensure validity and reliability were not reported.

Interventions/Improvement Strategies:

TSS provided an evidence-based rationale for the selected interventions, citing various studies that reported the positive impact of coordinated discharge transition care on decreasing hospital readmission rates.

Barriers identified by Triple S included:

- Difficulty contacting the member during the inpatient admission, for a home visit or for follow-up phone calls due to problems with telephone access or lack of member response.
- Elderly members placed out of their usual home setting for care after discharge.
- Members refusing to participate in activities to improve self-management.
- Limited response from hospitals in completing and submitting timely admissions registers.
- Case manager direct communication with the physician due to delegation of an office administrator or internal case manager as the liaison between the MCO and the physician. This may prevent the treatment plan from being modified as needed and causing possible health risks for the member.
- Need for provider education regarding prescribing patterns consistent with guidelines.
- Inappropriate use of medications by patients.
- Multiple prescribers resulting in polypharmacy causing increased risk of drug-related problems such as adverse reactions and added medication costs.
- Because TSS is a PPO plan, many members have not selected a PCP and receive care through multiple physician specialists. The lack of a PCP or coordinating provider may hinder effective management of illness, negatively impact achievement of health goals, lessen continuity of care, increase use emergency services, and prevent a strong physician-patient relationship.

Triple S described a plan to mitigate these barriers including:

- Assigning an MCO UM nurses assigned to visit members admitted the inpatient hospitals, contact hospital social workers, and provide CM/UM contact information to the members.
- Conducting follow-up through home visits with at least three attempts in a one week period before declaring the member not available.
- Making at least three follow-up phone call attempts within seven working days.
- Involving caregivers in discharge transition plans.
- Maintaining additional phone numbers for member contact.
- Sending a mailing upon discharge to inform the case manager of the need for an assessment.
- Performing weekly data reconciliation to identify the total number of members admitted with CHF and using manual reconciliation to provide missing data.

- Referring the member to the MCO visiting physician for a home evaluation. The visiting physician act as the primary liaison for medication reconciliation and member education.
- Case managers will counsel members on medications prescribed upon discharge.
- Daily follow-up and coordination with hospital discharge planner.
- Working to encourage beneficiary to select primary care provider.

Provider-focused interventions:

- Coordinate follow-up care appointments with a PCP or cardiologist within 7 working days of discharge.

Triple S should consider provider-targeted interventions such as notifying PCPs of member discharge, working with hospitals and PCPs on a coordinated plan for discharge, and collaboration between care managers and the PCP office in the immediate post-discharge period.

Member-focused interventions:

- Implement a discharge transition process for members discharged with a CHF diagnosis. The process includes 3 interventions:
  - Creating a discharge care plan;
  - Coordinating an initial follow-up appointment within 7 working days of discharge; and
  - Conducting a medication reconcilliation within 7 working days of discharge.
- Develop, measure, and implement a patient satisfaction assessment for with the Case-Management Program. The stated timeline was to develop the program by May 2013, measure improvement in satisfaction by November 2013 and continue to measure satisfaction in measurement year (MY) 2 and MY 3.

No details are provided for how member satisfaction will be measured and the methodology for surveying members and calculating the results. In addition, a goal for the measurement is not stated.

Health Plan-focused intervention(s):

- Implementing a mechanism to register and track all members admitted with a diagnosis of CHF using the hospital admission register as the primary data source. The data will be matched with CCMS UM and CM data system to track the status of transition of care interventions within 7 working days of discharge.
- Assigning MCO UM nurses to visit members with inpatient admissions, contact hospital social workers, and provide CM/UM contact information to members.
- Maintaining additional phone numbers for member contact.
- Sending a mailing upon discharge to inform the case manager of the need for an assessment.
- Tracking post-discharge follow-up appointments with a PCP or cardiologist in the CCMS application. CCMS data will be verified against claims and encounter data to measure complaince with the established timeframes.

Data Analysis and Results:

No results were reported, as it appeared the project is in the development phase.

Triple S Salud HMO PIP 2012-2015 Glaucoma Screening in Older Adults						
Indicator(s)	**Baseline Rate 1/1/2011 12/31/11**	**Interim Rate yr 1 11/1/2012 – 10/31/2013**	**Interim Rate yr 2 11/1/2013- 10/31/2014**	**Final Rate yr 3 11/1/2014- 10/31/2015**	**Target or Goal Rate**	**Target or Goal Met?**
CHF member readmission rate	TBD	TBD	TBD	TBD	TBD	TBD

No results were reported as no measurements were conducted. The project was in the development phase.

Achievement of Improvement:

- Not applicable at this time as data are pending. The PIP was in the development phase.

Achievement of Sustained Improvement:

- Not applicable at this time as data are pending. The PIP was in the development phase.

Overall Credibility of Results and Validation Findings:

- The credibility of the PIP results cannot be evaluated at this time due to the pending remeasurement data. However, the methodological issues cited should be addressed prior to the next report.

Strengths:

- TSS selected a topic relevant to its membership which could result a decrease in readmission rates and improved coordination and continuity of care for members with CHF
- The PIP targets a chronic condition where improvement may result in decreased costs, increased member compliance with post discharge follow up care, increased medication adherence and improved member health & satisfaction**.**
- TSS researched evidenced-based best practices for reducing readmissions and incorporated them into the PIP interventions.
- The interventions involved Case Management nurses and physicians to facilitate the discharge coordination process both prior to and after discharge, including arranging follow up visits, medication reconciliation and PCP selection.
- The MCO conducted a root-cause analysis to identify barriers and developed mitigation plans to address the barriers.

Opportunities for Improvement:

- TSS did not directly state a study question – i.e., if the intervention will improve the outcome – in a question format.
- The MCO provide the rate of CHF readmissions as a percentage of all-cause readmissions.
- TSS set a goal of 85% compliance for completion of a member follow-up call within 7 days of discharge. A specific intervention to improve this and define an indicator to measure results against the 85% goal rate.

First Plus Performance Improvement Projects

PIP #1: Improving Member Satisfaction with the DME Approval and Delivery Process

Study Topic Selection:
The study rationale was supported by internal (complaints) and external (CAHPS survey) data. The PIP was conducted to evaluate and improve the level of member satisfaction with FP's Durable Medical Equipment (DME) approval and delivery process.

FP's internal 2012 Complaint Analysis (100% of all adjudicated complaints; 3 DME complaints of 11 total complaints) revealed that 27% of member complaints were DME-related. The analysis was conducted by FP's Grievances & Appeals Manager and the Quality Director. The 2012 Consumer Assessment of Health Care Providers and System (CAHPS) Survey revealed that 49% of FP's member responses identified varying degrees of dissatisfaction with how easily the member obtained the medical equipment through the health plan. Based on these results, FP determined there was an opportunity for improvement in the DME process.

Study Question(s) and Indicator(s)
First Plus did not identify a study question.

The indicator for this QIP was stated as:
The percentage of DME related complaints versus all complaints received.

FP also reported the results of its own DME Satisfaction Surveys conducted during Q1 and Q2 2013. The DME Satisfaction Survey was not used as an indicator, but rather for barrier analysis purposes.

The goal or target was to achieve a 30% decrease in member complaints related to FP's DME process.

The objective of the study was to address members' dissatisfaction with the FP's DME approval and delivery processes.

Study Population and Sampling:
The specifications for the indicator were as follows:

- The numerator was all member complaints received during the measurement period.
- The denominator was DME-related complaints received during the measurement period.

The baseline period was calendar year 2012.
The interim measurement period was Q1 & Q2 2013.
The final measurement was not reported.
The baseline and interim measurement periods were not comparable. Baseline was a calendar year, while the interim period was 6 months in duration.

The data source was FP's grievance/complaint data. FP did not provide information on how complaint data was recorded.

The study methodology was collection and analysis of complaints data by FP's Grievances & Appeals Manager and the Quality Director.

No sampling was conducted. All member complaints received during the baseline and interim periods were used. The populations for both the baseline and interim periods were very small (11 and 9 complaints, respectively). This brings into question the credibility of the data.

Data Collection Procedures:

The data collection method was conducted by the Appeals and Grievances staff, using FP's system for Appeals and Grievances.

Methods to ensure validity and reliability were not reported. FP did not provide information on how complaint data was recorded.

Issues identified with the survey data collection process include:

- FP did not provide a copy of the member survey for review.
- Only members with a DME-approval were chosen for the survey. Members with denials could have provided information on satisfaction with the pre-authorization process.
- There were no questions on the survey related to health plan performance (i.e., pre-authorization process).
- The method for completing the survey (i.e., mail, online, phone, in-person, etc.) was not identified.
- The survey results were not stratified to indicate the degrees of member satisfaction with FP's DME process. For example, the CAHPS satisfaction survey use the criteria of "always, usually, sometimes and never" to stratify member levels of satisfaction.
- The PIP report contains conflicting information on the timeframe for the DME Satisfaction Survey. It is not clear whether the reported results are from Q1 & Q2 2013 or from Q2 & Q3 2013. It appears that members were contacted during Q2 to report on their satisfaction during Q1 and that members were contacted during Q3 to report on their satisfaction during Q2. FP should clarify the time frames for the survey results.
- It is unclear why the denominator changed to 107 from 125 for satisfaction with the services (for what appears to be Q1 survey results).

Interventions/Improvement Strategies:

The MCO identified the following barriers/root causes:

- Challenges inherent in the DME process (member needs, costs & co-pays, knowledge deficits)
- Multiple parties (FP, the healthcare team, the DME suppliers) that impact the DME process and ultimately affect member satisfaction.

FP indicated that these barriers were mitigated by reinforcing communication among all parties and adherence to FP's and regulatory standards.

FP did not report the basis of the DME-related complaints. Members may have reported problems with the MCO's pre-authorization process. FP could have developed interventions to address these potential issues such as changing the pre-authorization process or providing member education regarding pre-authorization process.

The interventions consisted of the following:

Provider-focused interventions:

FP did not report provider-focused interventions for this PIP; however, it appears that the following were done:

- Reinforced the communication with key players (PCP, hospital, LTCFs, DME providers, Health Plan and members)
- Conducted retraining. FP did not identify which internal and\or external groups received the training, the type of training that was provided and any measurements of the effectiveness of the training.

Not much detail regarding these interventions is documented in the PIP report.

Member-focused interventions:

- Surveyed members about satisfaction with the DME approval and delivery process. This would be better characterized

Health Plan-focused intervention:

- Fielded a DME Satisfaction Survey.
- Evaluated policies and procedures (P&Ps). The PIP report did not describe which P&P's were evaluated, if any of the P&P's were changed, the criteria utilized to determine if a P&P should be changed and how changes (if any) impacted the DME process.

Additionally, the following intervention(s) was planned going forward:

- Continue to implement the interventions described with the goal of achieving a 30% reduction in member complaints regarding the DME process.

Data Analysis and Results:

The reported results are presented in the table below.

Improving Member Satisfaction with DME Approval and Delivery Process – Reported Results					
Indicator(s)	**Baseline Rate CY 2012**	**Interim Rate Q1/Q2 2013**	**Percentage decrease from baseline**	**Target or Goal**	**Target or Goal Met?**
% of complaints related to DME approval & delivery process	27% (3/11)	22% (2/9)	19 %	-30%	No

During the 2012 baseline year, 3 of 11 (27%) adjudicated complaints were DME-related. The timeframe for the 2013 re-measurement period was Q1 and Q2 2013. During that time, 2 of 9 (22%) member complaints were DME-related. The decrease from 27% in 2012 to 22% in 2013 represents a 19% decrease in DME-related complaints.

FP conducted DME Satisfaction Surveys. A DME pre-authorization approval triggered a survey mailing. In Q1 2013, 125 of 309 members who had a DME pre-authorization approval in Q1 completed the survey (40.45% response rate). In Q2 2013: 194 of 530 members who had a DME pre-authorization approval completed the survey (37.00% response rate).

For Q2, improvement was noted in 4 of 6 categories, and the overall satisfaction rate increased from 97.87% to 99.92%. The member DME Approval & Delivery Process survey results are listed below:

Category	1st Qtr 2013	2nd Qtr 2013
Services Delivered	100.00%	100.00%
Time Delivered	93.6%	100.00%
All Items Delivered	98.4%	99.5%
Enrollee orientation about DME	97.6%	100.00%
DME contact information provided	97.6%	100.00%
Satisfaction with the services	100.00%	100.00%

Achievement of Improvement:
The percentage of member complaints decreased from 27% in the baseline period to 22% in the interim measurement period. The decrease from 27% to 22% represented a 19% decrease. The PIP did not achieve the goal of a 30% decrease in DME-related member complaints.

Achievement of Sustained Improvement:
FP did not conduct/report a final re-measurement for sustained improvement. Therefore, there was insufficient data to make a determination regarding sustained improvement. The PIP report stated that FP intended to continue the interventions going forward with the goal of achieving a 30% decrease in member complaints. A determination regarding sustained improvement is pending review of future results.

Overall Credibility of Results: (choose one)
There are one or more validation findings that indicate a bias in the PIP results.

- The baseline and interim measurement periods were not comparable. Baseline was a calendar year, while the interim period was 6 months in duration.
- The data source was FP's grievance/complaint data. FP did not provide information on how complaint data was recorded. Methods to ensure validity and reliability were not reported.
- The populations for both the baseline and interim periods were very small (11 and 9 complaints, respectively).
- There were several methodological issues with the DME-satisfaction survey. Detailed information was provided above.

Strengths:

- The PIP topic was chosen using which supported that the topic as relevant to the membership.
- The topic was one that demonstrated an opportunity for improvement.
- The focus of the PIP was one for which improvement could be achieved via interventions.
- The PIP demonstrated improvement in member complaints related to DME.
- The survey showed an increase in member satisfaction with the DME process.

Opportunities for Improvement:

- FP did not directly state the study question, i.e., "Will [the intervention] decrease the number of DME-related member complaints?"
- Related to methodology:
    a. The baseline and interim measurement periods were not comparable. Baseline was a calendar year, while the interim period was 6 months in duration.
    b. The data source was FP's grievance/complaint data. FP did not provide information on how complaint data was recorded. Methods to ensure validity and reliability were not reported.

c. The populations for both the baseline and interim periods were very small (11 and 9 complaints, respectively). This brings into question the credibility of the data.
d. There were several methodological issues with the DME-satisfaction survey. Detailed information was provided above. FP should clarify the timeframes for the member surveys were completed and only use Q 1 and Q2 2012 for comparison to Q1 and Q2 2013 to determine the actual reduction in # of DME-related complaints.
e. FP should conduct surveys for all 4Qs of 2013 to determine if there is an annual reduction in # of DME-related complaints and an increase in member satisfaction for 2012 vs. 2013.

- Related to interventions:
  a. FP did not report the basis of the DME-related complaints or assess this as a cause for dissatisfaction. FP should have analyzed the approval and delivery processes individually to determine if any one aspect of the overall process significantly impacted member satisfaction.
  b. FP did not identify which internal and\or external groups received the training, the type of training that was provided and any measurements of the effectiveness of the training. FP should have provided more detailed information on the interventions and reported on the impact each of the interventions achieved on member satisfaction.
  c. The PIP report did not describe which P&P's were evaluated, if any of the P&P's were changed, the criteria utilized to determine if a P&P should be changed and how changes (if any) impacted the DME process. FP should have provided more detailed information on the interventions and reported on the impact each of the interventions achieved on member satisfaction.
- Related to results:
  a. FP should have clarified why the denominator changed from 125 to 107 for Satisfaction with DME Services survey results.

6. HMO/PIHP ASSESSMENT OF COMPLIANCE WITH PRIOR RECOMMENDATIONS

Federal EQR regulations for external quality review results and detailed technical reports at §438.364 require that the EQR include in each annual report an assessment of the degree to which each health plan has addressed the recommendations for quality improvement made in the prior EQR technical report. The following table provides an assessment as to the degree to which the MCOs effectively addressed the improvement recommendations made by the prior EQRO in the prior EQR Technical Report 2011.

Activity	MCO	IPRO Recommendation	IPRO Assessment of Compliance
PIPs	APS	Ensure that performance improvement projects are methodologically sound and that goals are established in consideration of baseline measurement results.	Non-compliant
PIPs	APS	The specific recommendations for the 3 PIPs in development should be reviewed and the PIP methodologies revised and submitted for further review.	Non-compliant
PMs	APS	Report all required HEDIS measures for measurement year 2010 in June 2011.	Fully compliant
Compliance	APS	Ensure that acknowledgment letters are provided to members for grievances and appeal requests.	Non-compliant
Compliance	APS	Ensure that appeal notices include the member's right to request a state fair hearing as well as how to request the hearing, the member's right to continuation of benefits, and the circumstances under which a member may have to pay the cost of benefits	Substantially compliant
Compliance	APS	Ensure that policies/procedures related to appeals address the above requirements and that this information is provided to members.	Non-compliant
PIPs	Humana Medicaid	Ensure that performance improvement projects are included in the annual QI Evaluation	Non-compliant
Compliance	Humana Medicaid	Ensure that QI Committee minutes include discussion of QI activities and	Non-compliant

Activity	MCO	IPRO Recommendation	IPRO Assessment of Compliance
		reflect review, analysis and priority setting.	
Compliance	Humana Medicaid	Revise UM denial letters to include the member's right to request a state fair hearing as well as how to request the hearing.	Fully compliant
Compliance	Humana Medicaid	Ensure that a treatment plan is in place for member's enrolled in case management.	Fully compliant
PMs	Humana Medicaid	Continue to monitor and address HEDIS performance measures that fall below the Medicaid mean.	Minimally compliant
PMs	Humana Medicaid	Consider implementing a quality initiative, perhaps in the form of a PIP, to address screening measures that fall below the HEDIS 10th percentile, such as Well Child Care and Children and Adolescent Access to PCP.	Non-compliant
PMs	Humana Medicaid	Consider implementing quality initiatives, perhaps in the form of a PIP, to address Well Child and Prenatal performance measures.	Non-compliant

APPENDIX A

Medicaid Managed Care Compliance Monitoring

Objectives

Each annual detailed technical report must contain data collected from all mandatory EQR activities. Federal regulations at 42 CFR 438.358, delineate that a review of an MCO's compliance with standards established by the State to comply with the requirements of § 438.204(g) is a mandatory EQR activity. Further, this review must be conducted within the previous three-year period, by the State, its agent, or the EQRO.

ASES annually evaluates the MCOs' performance against contract requirements and state and federal regulatory standards through its EQRO contractor. In an effort to prevent duplicative review, federal regulations allows for use of the accreditation findings, where determined equivalent to regulatory requirements. For purposes of the review of the Puerto Rico MCOs, no requirements were deemed via accreditation. A full review of all requirements was conducted.

The annual compliance review for the contract year 2012-2013, conducted in December 2013/January 2014 addressed contract requirements and regulations within the following domains:

- Grievance System;
- Enrollee Rights and Protection;
- QAPI: Access;
- QAPI: Structure and Operations; and
- QAPI: Measurement and Improvement.

Data collected from the MCOs either submitted pre-onsite, during the onsite visit, or in follow-up, was considered in determining the extent to which the health plan was in compliance with the standards. Further descriptive information regarding the specific types of data and documentation reviewed is provided in the section "Description of Data Obtained" below and in this report under subpart, "Compliance Monitoring."

Technical Methods of Data Collection
In developing its review protocols, IPRO followed a detailed and defined process, consistent with the CMS EQRO protocols for monitoring regulatory compliance of MCOs and PIHPs. For each set of standards reviewed, IPRO prepared standard-specific worksheets with standard-specific elements (i.e., sub-standards). The worksheets include the following:

- Statement of federal regulation;
- Suggested Documentation/Evidence;
- Prior results and Follow-Up (not applicable for this review);
- Reviewer compliance determination;
- Descriptive findings and comments related to recommendations and commendable practices;

In addition, where applicable (e.g., member grievances), file review worksheets were created to facilitate complete and consistent file review.

Surveyor findings on the worksheets formed the basis for assigning preliminary and final designations. The standard designations used were as follows:

Standard Compliance Designations	
Designation	**Significance**
Full Compliance	MCO has met or exceeded the standard.
Substantial Compliance	MCO has met most requirements of the standard, but may be deficient in a small number of areas.
Minimal Compliance	MCO has met some requirements of the standard, but has significant deficiencies requiring corrective action.
Non-Compliance	MCO has not met the standard.
Not Applicable	The standard does not apply to the MCO.

Pre-Onsite Activities – Prior to the onsite visit, the review was initiated with an introduction letter, documentation request, and request for eligible populations for all file reviews.

The documentation request is a listing of pertinent documents for the period of review, such as policies and procedures, sample contracts, program descriptions, work plans, and various program reports. Additional documents were requested to be available for the onsite visit, such as reports and case files.

The eligible population request is a request for case listings for file reviews. For example, for member grievances, a listing of grievances for a selected quarter of the year; or, for care coordination, a listing of members enrolled in care management during a selected quarter of the year. From these listings, IPRO selected a random sample of files for review onsite.

Additionally, IPRO began its “desk review” or offsite review when the pre-onsite documentation was received from the plan.

Prior to the review, a notice was sent to the health plans including a confirmation of the onsite dates, an introduction to the review team members, the onsite review agenda, and an overall timeline for the compliance review activities.

Onsite Activities – The onsite review commenced with an opening conference, where staff was introduced, and an overview of the purpose and process for the review and onsite agenda were provided. Following this, IPRO conducted review of the additional documentation provided onsite, as well as the file reviews. Staff interviews were conducted to clarify and confirm findings. When appropriate, walkthroughs or demonstrations of work processes were conducted. The onsite review concluded with a closing conference, during which IPRO provided feedback regarding the preliminary findings, follow up items needed, and the next steps in the review process.

Description of Data Obtained

As noted in the Pre-Onsite Activities, in advance of the review, IPRO requested documents relevant to each standard under review, to support the health plan's compliance with federal and state regulations and contract requirements. This included items such as: policies and procedures; sample contracts; annual QI Program Description, Work Plan, and Annual Evaluation; Member and Provider Handbooks; access reports; committee descriptions and minutes; case files; program monitoring reports; and evidence of monitoring, evaluation, analysis and follow up. Additionally, as reported above under Onsite Activities, staff interviews, demonstrations, and walk-throughs were conducted during the onsite visit. Supplemental documentation was also requested for areas where IPRO deemed it necessary to support compliance. Further detail regarding specific documentation reviewed for each standard for the 2010 review is contained in the Compliance Monitoring section of this report.

Data Aggregation and Analysis

Post-Onsite Activities –As noted earlier, each standard reviewed was assigned a level of compliance ranging from Full Compliance to Non-Compliance. The review determination was based on IPRO's assessment and analyses of the evidence presented by the health plan. For standards where the plan was less than fully compliant, IPRO provided a narrative description of the evidence reviewed in the review tool, and reason for non-compliance. The plan was provided with the preliminary findings with the opportunity to submit a response and additional information for consideration. IPRO reviewed any responses submitted by the plan and made final review determinations.

APPENDIX B

Validation of Medicaid Managed Care Performance Improvement Projects

Objectives
Medicaid Managed Care Organizations (MCOs) implement performance improvement projects (PIPs) to assess and improve processes of care, and as a result improve outcomes of care. The goal of the PIP is to achieve significant and sustainable improvement in clinical and nonclinical areas. A mandatory activity of the External Quality Review Organization (EQRO) under the BBA is to review the PIP for methodological soundness of design, conduct and report to ensure real improvement in care and confidence in the reported improvements.

The Performance Improvement Projects (PIPs) were reviewed according to the Centers for Medicare and Medicaid (CMS) protocol described in the document Validating Performance Improvement Projects: A protocol for use in Conducting Medicaid External Quality Review Activities. The first process outlined in this protocol is assessing the methodology for conducting the PIP. This process involves the following ten elements:

- Review of the selected study topic(s) for relevance of focus and for relevance to the MCO's enrollment;
- Review of the study question(s) for clarity of statement;
- Review of selected study indicator(s), which should be objective, clear and unambiguous and meaningful to the focus of the PIP;
- Review of the identified study population to ensure it is representative of the MCO enrollment and generalizable to the plan's total population;
- Review of sampling methods (if sampling was used) for validity and proper technique;
- Review of the data collection procedures to ensure complete and accurate data was collected;
- Assessment of the improvement strategies for appropriateness;
- Review of the data analysis and interpretation of study results;
- Assessment of the likelihood that reported improvement is "real" improvement; and
- Assessment of whether the MCO achieved sustained improvement.

Following the review of the listed elements, the review findings are considered to determine whether or not the PIP findings should be accepted as valid and reliable.

Technical Methods of Data Collection
Methodology for validation of the PIPs was based on CMS' **"**Validating Performance Improvement Projects: A protocol for use in Conducting Medicaid External Quality Review Activities." Each PIP submitted by the MCOs was reviewed using this methodology, and each of the ten protocol elements was considered.

Description of Data Obtained
Each PIP was validated using the MCOs' PIP project reports and interviews of MCO staff during the onsite compliance reviews in December 2013/January 2014. The MCOs' QI Program Evaluations were also reviewed as part of the onsite.

Data Aggregation and Analysis
Strengths of each PIP and opportunities for improvement for each protocol element necessary for a valid PIP are documented in the technical report.

Validation findings were reviewed and, typically, a determination is made as to the overall credibility of the results of each PIP, with assignment of one of three categories:

- There were no validation findings that indicate that the credibility of the PIP results is at risk.
- The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution. Processes that put the conclusions at risk will be enumerated.
- There are one or more validation findings that indicate a bias in the PIP results. The concerns that put the conclusion at risk will be enumerated.

Since this was the first PIP validation review of the Puerto Rico MCOs' PIPs conducted by IPRO, and the majority of the PIPs were ongoing activities which had been reviewed previously, IPRO did not comment on the overall credibility. This determination had been made in prior reviews.

A report of the findings and strengths and weaknesses of each validated PIP was included in the Technical Report.

APPENDIX C

Validation of Performance Measures

Objectives

Medicaid Managed Care Organizations (MCOs) calculate performance measures to monitor and improve processes of care. As per the CMS Regulations, validation of performance measures is one of the mandatory EQR activities.

The primary objectives of the performance measure validation process are to assess the:

- MCO's process for calculating performance measures and to determine whether the process adhered to the specifications outlined for each measure
- Accuracy of the performance measure rates as calculated and reported by the MCO.

Performance Validation Review Methodology

IPRO auditors followed methodology consisting of the standard HEDIS auditor protocol to review the measures selected by ASES for the validation.

The following section provides a high level description of the 4 phases in the audit process and efficiencies that are built in to the process through the use of IPRO's proprietary tools and templates:

Phase 1. Pre-Onsite

- IPRO sends an introductory packet detailing the steps and critical dates in the audit process and outlining the ROADMAP requirements, and a sample onsite agenda
- Kick-off meeting, as needed
- Review of ROADMAP
- Pre-onsite documentation: This is sent to health plan at least 2 weeks prior to the onsite audit. This documentation, at a minimum includes:

  Pre-onsite IS Tool – provides the types of questions that the auditors will include in their interviews with health plan staff.

  Follow up documentation list: health plan provides an opportunity to compile any follow up items that are identified from ROADMAP review. This also significantly helps to avoid follow up after the onsite and prior to data validation.

  Table identifying measures to be reported by product line and measures for which source code review may be required.

  Final agenda that is prepared in discussions with health plan staff.

  IPRO offers to review survey sample frames, source code for applicable measures and medical record tools as early in the audit process as possible in order to help the health plan address any issues.

Phase 2. On-site Audit, Source Code Review and Follow-up

- Auditors use electronic tools during the onsite audit to ensure efficiency.
- To minimize the follow up items list, auditors work with the health plan staff so that all possible items and any source code is reviewed during the onsite.
- Closing conference: Auditors provide preliminary findings, any remaining follow up items list, and discuss any measures that might be at risk.

Within 10 business days from the date of onsite, auditors send closing conference notes, preliminary findings, and any remaining follow up items list.

Phase 3. Medical Record Review Validation

Auditors work with health plan staff in completing the following steps:

- Convenience sample validation: IPRO auditors conduct a convenience sample validation by reviewing a small number of medical records to identify any potential problems in the process that may require corrective action. IPRO auditors perform this step early in the medical review process to enable the health plan to address these issues prior to beginning the medical record abstraction process. Auditors waive this step if the health plan meets all requirements detailed in HEDIS Volume 5.
- Final statistical validation: Auditors conduct over read for 2 measures, up to 30 records per measure. Throughout the medical record validation process, auditors work with the health plan staff to provide any guidance or help needed.

Phase 4. Post-Onsite and Reporting

To validate the data in the data submission tool, auditors use electronic tools and various strategies including but not limited to the following:

- Comparing each MCO's rates with previous year's rates, if available
- Comparing plan rates with applicable benchmarks
- Validate and analyze data for reasonability, assess intra-measure comparison, etc.

Auditors provide findings as soon as possible in order to help the plan address any issues in the data submission tool. Auditors maintain frequent and timely communication via email and telephone with the health plan staff through the data validation process. Upon validation of final version, auditors assign final audit determinations in discussion with the health plan and will lock the data submission tool for final submission. At the close of the audit, auditors issue a Final Audit Report that contains the Final Audit Statement as well.