Commonwealth of Puerto Rico
Puerto Rico Health Insurance Administration

Annual External Quality Review Technical Report

Contract Years:
Medicaid 2013–2014
Medicare 2014

December 2015

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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 (MMC) plans and the Medicare Advantage Organizations (MAOs) contracted under the Medicare program.

Scope of EQR Activities Conducted

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

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

Validation of Performance Measures (PMs): IPRO conducted Healthcare Effectiveness Data and Information Set HEDIS®[1] compliance audits of the MCO/PIHP processes for calculation and reporting of HEDIS® performance measures in 2014 for HEDIS® 2014. 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.

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.

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

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: Quality

Overall APS performance in the domain of quality was fair.

The MCO reported two PIPs: Obesity and Depression and Depression and Well-Being for Members with Autism and ADHD. No data was reported for either PIP, therefore, it could not be determined if improvement was achieved. Strengths of the Obesity and Depression PIP included the MCO supporting the topic selection with data and evidence-based literature and interventions that involved regular provider and member contact. A relative strength of the PIP, Well-Being for Members with Autism and ADHD, was a well-defined study population. Methodological weaknesses were identified for both PIPs in the areas of indicator definitions, measurement periods and sampling strategy and data collection. Recommendations were also provided regarding conducting barrier analysis, providing more thorough descriptions of interventions, and using process measures to assess the progress and effectiveness of interventions.

In regard to compliance, 13 of 32 elements reviewed for QAPI – Measurement and Improvement, achieved full compliance during this year's compliance monitoring, 5 more than for the prior review. Fourteen elements scored substantial compliance and 5 scored minimal compliance. Deficiencies in this area related to reporting results of the PIPs and health information systems, ensuring accuracy, completeness and timeliness of encounter data submitted by providers, screening data for logic and consistency, and submission of encounter data. All of the 5 elements achieved minimal compliance in the prior review.

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 for reporting years 2012 - 2014:

- Follow-Up after Hospitalization for Mental Illness (FUH)
- Follow-Up for Children Prescribed ADHD Medications (ADD)
- Antidepressant Medication Management (AMM)

For ADD, rates ranked at or above Quality Compass™ Medicaid averages for only 2 of 9 regions for Initiation Phase and for Continuation & Maintenance Phase for 7 of 9 regions. For AMM, all rates benchmarked below the national Medicaid averages, as was the case for the prior two reporting periods.

In the domain of quality, IPRO recommends that APS:

- Ensure that performance improvement projects are methodologically sound and intervention strategies are evidence-based, developed based on identified barriers, and tracked using process measures.
- Examine the regulatory requirements designated not fully met and take corrective action to achieve compliance, especially for those with repeated deficiencies.
- Evaluate overall HEDIS® performance against the Quality Compass™[2] benchmarks, assess three-year trends for all measures, and assess region-specific performance and develop and implement targeted interventions to improve performance.

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

APS Healthcare – Medicaid: Timeliness

Overall APS' performance in the domain of timeliness was good.

Forty-one of 47 elements reviewed for the Grievance System were fully compliant. Five elements were substantially compliant, 1 element was minimally compliant, and 0 elements were non-compliant. This is a substantial improvement from the prior review when only 21 elements were fully compliant. Minimal was assessed for elements related to enrollee rights during the appeals process. Additionally, performance for the HEDIS measure Follow-up after Hospitalization for Mental Illness ranked at or above the Medicaid national average for 7 of 9 regions for 7-day follow-up and 8 of 9 regions for 30-day follow-up.

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 (IET)

Rates for IET varied across the age groups, but the total rates for both Initiation and Engagement fell below the national Medicaid averages for all regions. In contrast, performance for the HEDIS measure FUH ranked at or above the Medicaid national average for 7 of 9 regions for 7-day follow-up and 8 of 9 regions for 30-day follow-up.

In the domain of timeliness, IPRO recommends that APS:

- Evaluate overall HEDIS® performance against the Quality Compass™[3] benchmarks and assess three-year trends and region-specific performance and develop and implement targeted interventions to improve performance.

APS Healthcare – Medicaid: Access

Overall APS' performance in the domain of access was mixed.

QAPI – Access was among the strongest performing compliance domains for APS. For this domain, 42 of 43 elements reviewed were fully compliant, 1 was substantially compliant, and none were minimally or non-compliant.

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 (IAD)
- Mental Health Utilization (MPT)

Among the measures of behavioral health services, IAD was among those that demonstrated poor performance, consistently ranking below the Medicaid mean for all 3 years, 2012 - 2014. This was an area of poor performance in the prior external quality review. Performance for the MPT measure varied, with 2 of the 4 numerator rates (Any, Outpatient & ED) exceeding the mean in most regions.

In the domain of access, IPRO recommends that APS:

- 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 to improve access to these important services.

Triple-S (SSS) – Medicaid: Quality

Overall Triple-S' performance in the domain of quality was fair

Triple-S reported three PIPs for the Medicaid population: Appropriate Medications for People with Asthma, Blood Pressure Control and Cholesterol for Members with Hypertension, and Screening for Diabetics – HbA1c Testing and Eye Exams. The rationale for each of the 3 PIPs was weak, lacking data to support the topic relevance to the MCO's members. The MCO did not define the criteria used to identify members with severe asthma, severe hypertension, and severe diabetes. The study population was limited to members actively participating in the MCO's Disease Management program, thereby limiting the scope of the PIPs, excluding the majority of members with those conditions, and biasing

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

the PIP toward improvement. It should be noted that the MCO improved some of the methodological issues from the prior review. The results were presented more clearly and the measurement timeframes were appropriate (quarterly).

Compliance in the domain of QAPI – Measurement and Improvement was substantially improved. The MCO achieved full compliance for 32 of 32 elements.

Triple-S reported the following HEDIS® Effectiveness of Care performance measures for the North, Metro North, East, Northeast, Southeast, San Juan, Southwest, and West and Virtual regions for reporting years 2012 - 2014:

- Adult BMI Assessment (BMI)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)
- Childhood Immunization (CIS)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Chlamydia Screening in Women (CHL)
- Appropriate Treatment for Children with URI (URI)
- Use of Appropriate Medications for People with Asthma (ASM)
- Cholesterol Management for Patients with Cardiovascular Conditions (CMC)
- Controlling High Blood Pressure (CBP)
- Comprehensive Diabetes Care (CDC)

Performance in the HEDIS® Effectiveness of Care domain presented substantial opportunity for improvement. The majority of Triple-S' rates fell below the Quality Compass™ means for all three reporting periods.

In the domain of quality, IPRO recommends that Triple-S:

- Expand the focus of the PIPs to address all members with asthma, hypertension, or diabetes.
- Evaluate overall HEDIS® performance against the Quality Compass™[4] benchmarks, assess three-year trends for all measures, and assess region-specific performance and develop and implement targeted interventions to improve performance.

Triple-S (SSS) – Medicaid: Timeliness

Overall Triple-S' performance in the domain of timeliness was fair.

Compliance with standards for Grievance System was improved. Forty of 47 elements reviewed for Grievance achieved full compliance. The remaining 7 elements scored substantial compliance.

Triple-S reported the following HEDIS® measures related to timeliness for the North, Metro North, East, Northeast, Southeast, San Juan, Southwest, and West and Virtual regions for reporting years 2012 - 2014:

- Childhood Immunization (CIS)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Prenatal and Postpartum Care (PPC)
- Well-Child Visits in the First 15 Months of Life – 6+ Visits (W15)
- Adolescent Well-Care Visits (AWC)

Most HEDIS® measures related to timeliness of care performed below the national Medicaid mean, with the exception of BCS for a few regions.

In the domain of timeliness, IPRO recommends that Triple-S:

- Consider implementing a quality initiative or PIP to address HEDIS® measures that fell below the mean consistently, such as Well Child Care and Timeliness of Prenatal Care.

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

Triple-S (SSS) – Medicaid: Access

Overall Triple-S performance in the domain of access was fair.

All elements reviewed for QAPI – Access were fully compliant, as was the case for the prior review.

Triple-S reported the following HEDIS® measures related to access for the North, Metro North, East, Northeast, Southeast, San Juan, Southwest, and West and Virtual regions for reporting years 2012 - 2014:

- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Children's and Adolescents' Access to Primary Care Practitioners (CAP)
- Annual Dental Visit (ADV)
- Prenatal and Postpartum Care (PPC)
- Frequency of Prenatal Care > 80% of EV (FPC)
- Well-Child Visits in the First 15 Months of Life – 6+ Visits (W15)
- Adolescent Well-Care Visits (AWC)

For all 3 reporting periods, rates for these measures ranked below the Medicaid mean with few exceptions. Annual Dental Visits ranked above the mean for 6 of 9 regions.

In the domain of access, IPRO recommends that Triple-S:

- Consider implementing PIPs and/or quality initiatives to address preventive and well care for children and perinatal care.

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 2013-2014 as set forth in 42 CFR §438.356(a)(1). After completing the EQR process, IPRO prepared this *2013-2014 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 2013-2014:

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

- MCOs for physical health coverage: Triple-S.
- Managed 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, Constellation, First Plus, Humana, Medical Card System (MCS), 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. An updated Quality Strategy was developed by Puerto Rico in the fall of 2013 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.

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 2013-2014. The information is derived from IPRO's conduct of the annual compliance reviews in August/September 2015.

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 2015 Medicaid Compliance Review Findings for Contract Year 2013–2014

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 found minimally or non-compliant. Assessment of the effectiveness of the plan's progress for elements not compliant in the prior review follows the 2015 findings.

Table 1: APS – Summary of 2015 MMC Compliance Review Findings

APS Healthcare: Summary of 2015 Medicaid Managed Care Compliance Review Findings (Review Year 2013–2014)					
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	41	5	1	0
Enrollee Rights and Protections	43	42	1	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	43	42	1	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	5	5	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	32	13	14	5	0

Table 2: APS – 2015 MMC Compliance Review: Minimal and Non-Compliant Elements

APS Healthcare: 2015 Medicaid Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2013–2014)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	▪ Provide the enrollee and representative opportunity, before and during the appeals process, to examine the enrollee's case file and all appropriate records during the appeals process. **Minimal Compliance:** This member must be informed of the right to examine the case file with the initial denial, acknowledgement letter, and resolution notice.
Enrollee Rights and Protections	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Access	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ The results of the MCO's performance improvement projects (PIPs). **Minimal Compliance:** The plan should include a discussion of PIP results, analysis and proposed next steps in the Program Evaluation. ▪ Ensure that data received from providers is accurate and complete. **Minimal Compliance:** The plan should address encounter data processes in policy and procedure and ensure accuracy and completeness of data is monitored. ▪ Verifying the accuracy and timeliness of reported data. **Minimal Compliance:** The plan should address encounter data processes in policy and procedure and ensure accuracy and completeness of data is monitored. ▪ Screening the data for completeness, logic, and consistency. **Minimal Compliance:** The plan should address encounter data processes in policy and procedure and ensure accuracy and completeness of data is monitored. ▪ Make all collected data available to the State and upon request to CMS, as required. **Minimal Compliance:** The plan should address encounter data processes in policy and procedure and monitor accuracy and completeness of data submitted to ASES.

*Compliance is defined as having Full or Substantial Compliance.

Table 3: APS – 2015 MMC Compliance Review: Follow-Up for Previous Minimal and Non-Compliant Elements

APS Healthcare: 2015 Medicaid Managed Care Compliance Review – Follow-Up for Elements Minimal and Non-Compliant in 2013/2014 Review (Review Year 2012–2013)	
Description of Review Findings Minimal and Non-Compliant	**Follow-Up Findings: Current Status**
Standard: Grievance System	
Provisions for UM decisions that are not reached within required time frame. **Non-Compliance:** P/Ps should address provisions for UM decisions that are not reached within required time frame	▪ 2015 Review Determination: **Full Compliance**
Acknowledgement of receipt of appeals. **Minimal Compliance:** P/P should address acknowledgement of receipt of appeals; there should be an appeals letter template; and all appeals files should include an acknowledgement letter where necessary.	▪ 2015 Review Determination: **Substantial Compliance**
Enrollee's right to examine the case file during the appeal process. **Minimal Compliance:** The template appeal resolution letters and the Member Handbook should address the right to request the case file during the appeals process, not only after the appeal is resolved. Files should contain evidence that an acknowledgement letter was sent.	▪ 2015 Review Determination: **Minimal Compliance**
Timeframe for written resolution of appeals within 30 calendar days/with extension if needed. **Minimal Compliance:** Appeals files should contain written resolution where applicable.	▪ 2015 Review Determination: **Substantial Compliance**
Expedited appeals will be resolved and the party given written notice of the resolution within 72 hours. **Minimal Compliance:** Appeals files should contain written resolution letter where applicable.	▪ 2015 Review Determination: **Full Compliance**
Written notice of appeal disposition will be sent for all appeals and oral notice will be provided for expedited appeals. **Minimal Compliance:** Appeals files should contain written resolution letter where applicable. Liability for the cost of benefits if the ALH upholds the denial.	▪ 2015 Review Determination: **Full Compliance**
Provide or authorize services not provided while the appeal is pending if the decision is overturned. **Non-Compliance:** P/P should address the requirement to provide or authorize services not provided while the appeal is pending if the decision is overturned.	▪ 2015 Review Determination: **Full Compliance**
Pay for services provided while the appeal is pending if the decision is overturned. **Non-Compliance:** P/P should address the requirement to pay for services provided while the appeal is pending if the decision is overturned.	▪ 2015 Review Determination: **Full Compliance**
Standard: Quality Assessment and Performance Improvement (QAPI) - Access	
Monitor the number of providers who are not accepting new patients.	▪ 2015 Review Determination: **Substantial Compliance**

APS Healthcare: 2015 Medicaid Managed Care Compliance Review – Follow-Up for Elements Minimal and Non-Compliant in 2013/2014 Review (Review Year 2012–2013)	
Description of Review Findings Minimal and Non-Compliant	**Follow-Up Findings: Current Status**
Non-Compliance: APS should monitor and report the number of providers who are not accepting new patients.	
Sharing information on ISHCN with other MCOs that serve the member to prevent duplication of services. **Minimal Compliance:** P/P should address sharing information on ISHCN with other MCOs that serve the member to prevent duplication of services.	▪ 2015 Review Determination: **Full Compliance**
Standard: Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	
Evidence of review and update of CPGs. **Minimal Compliance:** Evidence of review and update of CPGs should be provided.	▪ 2015 Review Determination: **Full Compliance**
Report the results of each MCO's … performance improvement projects. **Minimal Compliance:** Include a discussion of PIP results and analysis and proposed next steps in the Program Evaluation.	▪ 2015 Review Determination: **Minimal Compliance**
Collect data on enrollee and provider characteristics…and on services furnished to enrollees through an encounter data system or other methods. **Minimal Compliance:** Establish a P/P to address encounter data processes and ensure accuracy and completeness of data is monitored. Complete corrective actions for high and moderate risk areas identified in an audit.	▪ 2015 Review Determination: **Substantial Compliance**
Ensure that data received from providers is accurate and complete. **Minimal Compliance:** Establish a P/P to address encounter data processes and ensure accuracy and completeness of data is monitored.	▪ 2015 Review Determination: **Minimal Compliance**
Verify the accuracy and completeness of submitted data. **Minimal Compliance:** Establish a P/P to address encounter data processes and ensure accuracy and completeness of data is monitored.	▪ 2015 Review Determination: **Minimal Compliance**
Screen data for completeness, logic, and consistency. **Minimal Compliance:** Establish a P/P for encounter data processes and ensure accuracy and completeness of data is monitored.	▪ 2015 Review Determination: **Minimal Compliance**
Make all collected data available to the State and upon request to CMS. **Minimal Compliance:** Establish a P/P for and provide documentation of submission of encounter data to ASES.	▪ 2015 Review Determination: **Minimal Compliance**

Triple-S Medicaid Compliance Review Findings for Contract Year 2013–2014

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 found minimally or non-compliant. Assessment of the effectiveness of the plan's progress for elements not compliant in the prior review follows the 2015 findings.

Table 4: Triple-S – Summary of 2015 MMC Compliance Review Findings

Triple-S: Summary of 2015 Medicaid Managed Care Compliance Review Findings (Review Year 2013–2014)					
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	7	0	0
Enrollee Rights and Protections	49	48	0	0	1
Quality Assessment and Performance Improvement (QAPI) – Access	45	45	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	21	21	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	32	32	0	0	0

Table 5: Triple-S – 2015 MMC Compliance Review: Minimal and Non-Compliant Elements

Triple-S: 2015 Medicaid Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2013–2014)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	▪ All applicable requirements were Compliant.*
Enrollee Rights and Protections	▪ The post-stabilization care service rules set forth at 422.113(c). **Non-Compliance:** This could not be found in the documentation provided. The Complex Case Management Policy is not a document that is provided to the member and only relates to complex case management, not to the general membership.
Quality Assessment and Performance Improvement (QAPI) – Access	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

Table 6: Triple-S – 2015 MMC Compliance Review: Follow-Up for Previous Minimal and Non-Compliant Elements

Triple-S Health Plan: 2015 Medicaid Managed Care Compliance Review – Follow-Up for Elements Minimal and Non-Compliant in 2013/2014 Review (Review Year 2012–2013)	
Description of Review Findings Minimal and Non-Compliant	**Follow-Up Findings: Current Status**
Standard: Quality Assessment and Performance Improvement (QAPI) – Access	
MCO considers the number of network providers who are not accepting new Medicaid patients. **Non-compliance:** Ensure that P&Ps to ensure adequate access to care and accuracy of the Provider Directory address network providers who are not accepting new Medicaid patients.	▪ 2015 Review Determination: **Full Compliance**
Standard: Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	
Guidelines are adopted in consultation with contracting health care professionals. **Minimal Compliance:** Develop a P/P for adoption of clinical practice guidelines that defines how input from providers is incorporated.	▪ 2015 Review Determination: **Full Compliance**
The MCO must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. **Minimal Compliance:** Ensure analysis and actions taken regarding the quality and appropriateness of care for special needs populations.	▪ 2015 Review Determination: **Full Compliance**
PIPs include planning and initiation of activities for increasing or sustaining improvement. **Minimal Compliance:** Ensure barrier analyses and/or re-evaluation and subsequent revision of interventions to increase or sustain improvement.	▪ 2015 Review Determination: **Full Compliance**
Each MCO … must report the status and results of each project to the State as requested. **Non-Compliance:** Ensure that PIPs are submitted to ASES.	▪ 2015 Review Determination: **Full Compliance**
The State must review, at least annually, the impact and effectiveness of each MCO's… quality assessment and performance improvement program. **Minimal Compliance:** Ensure that the annual QI Evaluation addresses the Medicaid/Mi Salud! product line.	▪ 2015 Review Determination: **Full Compliance**
The MCO reports performance on the standard measures as required. **Minimal Compliance:** Ensure that the annul QI Evaluation addresses performance measures for the Medicaid/Mi Salud! product line.	▪ 2015 Review Determination: **Full Compliance**
The MCO reports the of performance improvement projects. **Minimal Compliance:** Ensure that the annual QI Evaluation addresses PIPs for the Medicaid/Mi Salud! product line.	▪ 2015 Review Determination: **Full Compliance**
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:** Ensure that the annual QI Evaluation addresses the Medicaid/Mi Salud! product line.	▪ 2015 Review Determination: **Full Compliance**

Triple-S Health Plan: 2015 Medicaid Managed Care Compliance Review – Follow-Up for Elements Minimal and Non-Compliant in 2013/2014 Review (Review Year 2012–2013)	
Description of Review Findings Minimal and Non-Compliant	**Follow-Up Findings: Current Status**
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:** Develop P/Ps for collecting, producing and submitting encounter data.	▪ 2015 Review Determination: **Full Compliance**
The MCO must collect data on enrollee and provider characteristics, and on services furnished to enrollees through an encounter data system. **Minimal Compliance:** Develop a P/P for collecting, producing and submitting encounter data.	▪ 2015 Review Determination: **Full Compliance**
The MCO must have a process for collecting service information in standardized formats to the extent feasible and appropriate. **Minimal Compliance:** Develop a P/P for collecting, producing and submitting encounter data.	▪ 2015 Review Determination: **Full Compliance**
The MCO must make all collected data available to the State and upon request to CMS. **Minimal** Produce evidence of submission of encounter data to ASES.	▪ 2015 Review Determination: **Full Compliance**

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 2015 EQR evaluation, the PRHIA required all health plans to collect and report HEDIS® 2014 non-survey measures that reflect the services rendered to their Medicaid enrollees during 2013. 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 16, 2014. However, due to problems with Triple-S obtaining/verifying prior MCO claims/enrollment data, they were given an extension to 12/31/2014 to complete reporting. 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® 2012 through HEDIS® 2014 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® 2012-2014 National Medicaid Benchmarks.*

NCQA HEDIS® 2014 Compliance Audit

HEDIS® reporting is a contract requirement for Puerto Rico's Medicaid plans. In addition, the plans' HEDIS® measure calculation is audited by an NCQA-licensed audit organization, in accordance with NCQA's HEDIS® Compliance Audit specifications. In addition, for the Southwest, Southeast, and East Regions for HEDIS® 2014, Triple-S received Humana data (prior MCO) for services provided during 2013.

Triple-S stated that some of the Humana data was difficult to match up to their data because of differences in id numbers. Based on this information the auditor reviewed Triple-S' processes, systems and source code and found they met the requirements of the NCQA audit. However, since HEDIS® 2013 rates were not audited and with some data issues, the rates, especially for the Humana regions are for informational purposes only.

As part of the HEDIS® 2014 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® 2012–2014 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® 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.

Table 7: HEDIS® 2012 Measures – Triple-S

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%

HEDIS® 2012 Measure/Data Element	Northeast	MetroNorth	North	San Juan	West	East	Southeast	Southwest	Virtual
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%**
Chlamydia Screening in Women (CHL)									
16-20 Years	27.65%	28.10%	30.43%	28.51%	33.95%	NP	NP	NP	14.29%
21-24 Years	26.96%	27.67%	28.37%	28.07%	32.59%	NP	NP	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%
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%

HEDIS® 2012 Measure/Data Element	Northeast	MetroNorth	North	San Juan	West	East	Southeast	Southwest	Virtual
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.

Table 8: HEDIS® 2013 Measures – Triple-S

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%
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%

HEDIS® 2013 Measure/Data Element	Northeast	MetroNorth	North	San Juan	West	East	Southeast	Southwest	Virtual
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	**N/A**
51-64 years	66.92%	64.74%	69.57%	63.49%	62.43%	NP	NP	NP	**N/A**
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%
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%

HEDIS® 2013 Measure/Data Element	Northeast	MetroNorth	North	San Juan	West	East	Southeast	Southwest	Virtual
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%

NP: not provided

For HEDIS® 2014, Triple-S provided benefits to members in all regions.

Table 9: HEDIS® 2014 Measures – Triple-S

HEDIS® 2014 Measure/Data Element	Northeast	MetroNorth	North	San Juan	West	East	Southeast	Southwest	Virtual
Effectiveness of Care: Prevention and Screening									
Adult BMI Assessment (ABA)	22.63%	17.03%	27.74%	32.85%	15.57%	18.98%	48.18%	22.14%	21.55%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)									
BMI Percentile	14.11%	6.08%	16.55%	19.95%	27.01%	22.14%	51.58%	10.71%	11.44%
Counseling for Nutrition	19.22%	11.68%	20.92%	44.53%	22.38%	20.92%	52.07%	15.33%	18.25%
Counseling for Physical Activity	15.09%	7.06%	18.73%	28.71%	19.95%	17.27%	41.61%	9.25%	15.33%
Childhood Immunization Status (CIS)									
DTaP	25.06%	30.90%	57.42%	48.18%	50.36%	29.44%	33.82%	31.87%	28.79%
IPV	31.14%	38.93%	66.67%	52.07%	57.18%	36.74%	40.15%	36.98%	34.09%
MMR	59.61%	74.94%	76.16%	77.62%	73.97%	52.07%	57.42%	57.66%	49.24%
HiB	36.01%	53.28%	70.80%	60.10%	68.61%	40.15%	40.39%	39.66%	40.15%
Hepatitis B	24.33%	30.17%	61.80%	49.88%	49.64%	34.06%	38.93%	35.77%	31.06%
VZV	52.07%	69.10%	72.02%	73.72%	72.51%	52.07%	53.77%	59.61%	50.76%
Pneumococcal Conjugate	15.09%	27.01%	49.15%	43.07%	45.50%	26.03%	31.63%	28.95%	27.27%
Hepatitis A	63.75%	60.34%	69.83%	77.37%	75.67%	49.88%	56.93%	60.34%	52.27%
Rotavirus	21.41%	25.06%	44.53%	34.06%	47.20%	24.33%	30.17%	30.41%	15.91%
Influenza	3.65%	6.81%	11.44%	2.92%	15.09%	5.60%	9.73%	14.84%	9.09%
Combination #2	16.06%	22.14%	48.66%	40.15%	39.17%	21.17%	30.90%	27.98%	25.00%
Combination #3	11.19%	18.73%	42.09%	36.25%	35.52%	18.49%	27.25%	23.36%	23.48%
Combination #4	10.71%	17.52%	38.93%	34.79%	33.82%	17.03%	26.52%	21.65%	21.21%
Combination #5	8.27%	13.63%	31.63%	23.84%	30.90%	13.63%	22.14%	19.22%	12.12%
Combination #6	2.19%	3.65%	8.76%	1.22%	8.27%	2.92%	7.30%	9.49%	7.58%
Combination #7	8.03%	13.14%	29.93%	23.36%	29.44%	12.65%	21.65%	17.76%	12.12%
Combination #8	2.19%	3.41%	8.52%	1.22%	8.03%	2.92%	7.30%	9.00%	6.82%
Combination #9	1.95%	3.16%	6.57%	0.97%	7.54%	2.19%	6.81%	7.79%	3.79%
Combination #10	1.95%	2.92%	6.33%	0.97%	7.54%	2.19%	6.81%	7.30%	3.79%
Breast Cancer Screening (BCS)	**61.68%**	**61.61%**	**62.98%**	55.40%	57.66%	43.84%	46.67%	44.74%	0.00%
Cervical Cancer Screening (CCS)[1]	50.85%	46.72%	42.09%	49.64%	47.69%	43.07%	45.99%	44.04%	44.44%
Chlamydia Screening in Women (CHL)									
16-20 Years	46.19%	36.48%	38.27%	44.02%	44.25%	28.85%	26.43%	23.12%	49.88%
21-24 Years	44.08%	34.94%	39.07%	44.22%	48.24%	28.15%	27.94%	30.52%	**66.67%**

HEDIS® 2014 Measure/Data Element	Northeast	MetroNorth	North	San Juan	West	East	Southeast	Southwest	Virtual
Total	44.97%	35.63%	38.73%	44.13%	46.55%	28.45%	27.25%	27.14%	50.35%
Effectiveness of Care: Respiratory Conditions									
Appropriate Treatment for Children With URI (URI)	80.34%	78.59%	75.76%	81.89%	84.35%	**85.24%**	79.03%	84.69%	75.05%
Use of Appropriate Medications for People With Asthma (ASM)									
5-11 years	60.73%	69.89%	68.86%	52.36%	55.42%	**91.19%**	81.82%	81.43%	73.33%
12-18 years	79.52%	64.34%	72.90%	67.16%	49.30%	**90.96%**	75.51%	75.00%	66.67%
19-50 years	65.20%	60.26%	71.62%	62.00%	51.63%	**85.30%**	**77.68%**	**80.66%**	50.00%
51-64 years	**82.35%**	73.57%	**80.36%**	**86.32%**	71.54%	**89.83%**	**85.86%**	**86.32%**	**100.00%**
Total	69.33%	66.79%	72.75%	63.76%	56.20%	**88.81%**	**80.67%**	**81.71%**	70.00%
Effectiveness of Care: Cardiovascular									
Cholesterol Management for Patients With Cardiovascular Conditions (CMC)									
LDL-C Screening Performed	65.45%	69.34%	68.86%	69.40%	49.39%	64.72%	73.24%	70.80%	**100.00%**
Controlling High Blood Pressure (CBP)	26.28%	13.63%	29.44%	40.88%	13.14%	23.60%	28.71%	21.17%	33.33%
Effectiveness of Care: Diabetes									
Comprehensive Diabetes Care (CDC)									
Hemoglobin A1c (HbA1c) Testing	64.23%	68.25%	68.43%	63.87%	48.72%	51.82%	61.13%	55.11%	55.56%
Eye Exam (Retinal) Performed	22.26%	21.35%	20.62%	20.44%	19.89%	16.97%	12.77%	14.23%	22.22%
LDL-C Screening Performed	64.23%	64.42%	62.04%	59.31%	45.62%	50.91%	64.96%	61.68%	50.00%
Medical Attention for Nephropathy	76.46%	77.92%	76.28%	72.26%	70.80%	77.92%	**79.20%**	76.82%	5.56%
Access/Availability of Care									
Adults' Access to Preventive/Ambulatory Health Services (AAP)									
20-44 Years	60.59%	62.45%	68.71%	61.09%	59.17%	54.79%	54.06%	56.44%	44.63%
45-64 Years	33.74%	76.83%	81.22%	77.24%	76.50%	70.23%	69.72%	72.92%	66.67%
65+ Years	1.06%	78.46%	82.74%	80.09%	80.52%	69.80%	75.60%	76.30%	NP
Total	67.37%	68.75%	74.26%	69.29%	67.04%	61.24%	61.30%	63.84%	44.81%
Children and Adolescents' Access to Primary Care Practitioners (CAP)									
12-24 Months	70.87%	83.91%	84.43%	84.33%	83.33%	71.66%	65.44%	78.94%	71.77%
25 Months - 6 Years	69.81%	77.16%	79.44%	75.24%	77.23%	61.20%	55.16%	68.02%	71.86%
7-11 Years	64.62%	72.20%	75.45%	65.37%	77.44%	69.62%	60.02%	73.32%	74.26%
12-19 Years	56.56%	65.17%	69.23%	56.54%	67.73%	60.67%	52.91%	64.27%	69.01%
Annual Dental Visit (ADV)	**53.90%**	**57.20%**	**58.29%**	**56.42%**	**57.28%**	32.80%	29.97%	29.05%	**58.44%**
Prenatal and Postpartum Care (PPC)									
Timeliness of Prenatal Care	72.26%	76.64%	79.32%	65.69%	71.78%	18.25%	18.49%	18.98%	53.51%
Postpartum Care	21.17%	19.46%	20.44%	19.95%	18.25%	17.76%	16.30%	19.46%	15.79%

HEDIS® 2014 Measure/Data Element	Northeast	MetroNorth	North	San Juan	West	East	Southeast	Southwest	Virtual
Use of Services									
Frequency of Prenatal Care (FPC)									
< 21 % of EV	4.14%	3.41%	3.65%	4.38%	4.14%	**80.29%**	**76.64%**	**77.86%**	**17.54%**
21-40% of EV	3.65%	2.19%	3.65%	4.62%	3.41%	7.30%	**12.90%**	**12.65%**	**12.28%**
41-60 % of EV	**9.73%**	**9.25%**	**9.25%**	**17.52%**	**12.65%**	2.92%	3.65%	3.65%	**22.81%**
61-80 % of EV	**27.74%**	**21.17%**	**29.20%**	**26.03%**	**40.63%**	4.14%	4.87%	2.68%	**21.93%**
> 80% of EV	54.74%	**63.99%**	54.26%	47.45%	39.17%	5.35%	1.95%	3.16%	25.44%
Well-Child Visits in the First 15 Months of Life (W15)									
0 Visits	**72.02%**	**66.67%**	**62.04%**	**44.28%**	**53.04%**	**52.55%**	**50.12%**	**47.93%**	**66.22%**
1 Visit	**13.14%**	**14.60%**	**15.33%**	**22.38%**	**18.73%**	**16.79%**	**18.00%**	**11.92%**	**12.16%**
2 Visits	**7.54%**	**8.03%**	**8.76%**	**11.68%**	**10.46%**	**8.03%**	**10.95%**	**9.73%**	**9.46%**
3 Visits	1.70%	5.11%	4.14%	**9.25%**	**7.30%**	**5.35%**	**5.35%**	**9.25%**	**5.41%**
4 Visits	3.16%	2.92%	2.43%	5.84%	3.41%	5.84%	5.11%	6.33%	5.41%
5 Visits	1.70%	0.97%	1.46%	3.65%	2.68%	2.92%	3.89%	7.30%	0.00%
6+ Visits	0.73%	1.70%	5.84%	2.92%	4.38%	8.52%	6.57%	7.54%	1.35%
Adolescent Well-Care Visits (AWC)	18.25%	16.30%	17.52%	24.33%	12.41%	13.14%	22.14%	12.90%	14.36%

[1]HEDIS® Benchmarks for the Cervical Cancer Screening (CCS) measure was not available in Quality Compass 2014.
N/A: 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.

Table 10: HEDIS® 2012 Behavioral Health Measures – APS

2012 HEDIS® Behavioral 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	**N/A**	**N/A**	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	**N/A**	**N/A**	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%

NP: not provided

Table 11: HEDIS® 2013 Behavioral Health Measures – APS

2013® HEDIS® Behavioral 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%**

N/A; not applicable; NP: not provided

Table 12: HEDIS® 2014 Behavioral Health Measures – APS

2014 HEDIS® Behavioral 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	**67.7%**	**56.6%**	**64.6%**	**50.1%**	**66.3%**	40.9%	**46.2%**	**63.2%**	33.8%
Follow-up after hospitalization for mental illness 30 days	**81.3%**	**74.1%**	**78.5%**	**68.6%**	**78.5%**	**61.1%**	57.7%	**78.9%**	**61.7%**
Follow-up care for children prescribed ADHD medication (ADD)									
Initiation Phase	26.6%	28.2%	26.2%	23.2%	**40.2%**	27.6%	34.5%	**41.8%**	36.0%
Continuation and Maintenance Phase	45.6%	**59.5%**	**48.5%**	**58.8%**	**69.8%**	41.4%	**53.8%**	**69.1%**	**53.3%**
Initiation and Engagement of Alcohol & Other Drug Dependence Treatment (IET)									
Initiation 13 - 17 years old	34.29%	N/A	28.9%	**51.7%**	33.3%	N/A	31.3%	21.9%	20.00%
Initiation ≥ 18 years old	**42.3%**	**43.3%**	35.3%	**51.5%**	**41.5%**	**40.0%**	**48.2%**	37.5%	32.26%
Initiation TOTAL	42.12%	NP	35.05%	51.51%	41.17%	NP	47.65%	36.59%	26.79%
Engagement 13 - 17 years old	2.86%	NP	5.3%	**20.7%**	3.3%	NP	6.3%	6.3%	8.00%
Engagement ≥ 18 years old	**17.4%**	**18.0%**	**13.3%**	**23.9%**	**17.7%**	**10.8%**	**28.5%**	**14.2%**	3.23%
Engagement TOTAL	17.04%	NP	13.06%	23.76%	17.07%	NP	27.87%	13.75%	5.36%
Antidepressant Medication Management (AMM)									
Effective Acute Phase 84 days	32.6%	32.1%	37.3%	31.1%	33.7%	34.9%	37.1%	42.5%	31.7%
Effective Continuation Phase 180 days	15.5%	16.2%	17.8%	14.3%	16.3%	17.0%	18.2%	22.8%	14.6%
Identification of Alcohol and other Drug Services (IAD)									
Any	0.85%	0.96%	0.82%	0.82%	0.80%	1.12%	0.84%	0.75%	1.55%
Inpatient	0.08%	0.12%	0.12%	0.12%	0.13%	0.16%	0.18%	0.10%	0.08%
IOP and Partial	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Outpatient and ED	0.82%	0.91%	0.77%	0.77%	0.74%	1.05%	0.75%	0.71%	1.51%
Mental Health Utilization (MPT)									
Any	**15.07%**	**16.68%**	**16.11%**	12.12%	**16.89%**	**13.86%**	**13.49%**	11.48%	**51.05%**
Inpatient	0.38%	0.55%	1.02%	0.58%	0.88%	0.70%	0.69%	0.47%	**3.14%**
IOP and Partial	0.13%	0.22%	0.38%	0.11%	0.07%	0.23%	0.03%	0.02%	0.35%
Outpatient and ED	**14.99%**	**16.60%**	**15.88%**	12.01%	**16.78%**	**13.72%**	**13.38%**	11.40%	**49.90%**

N/A: not applicable; 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® 2012-2014.

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® 2012-2014.

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 2012 and 2013, with the exception of HEDIS® 2013 in the San Juan, East and Southwest regions. For HEDIS® 2014 all regions reported antigens and combination rates below the NCAA HEDIS® means.

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® 2012, East and Southeast were above the NCQA mean. For HEDIS® 2013, MetroNorth, North, Southeast, Southwest and Virtual were above the NCQA mean. For HEDIS® 2014, Northeast, MetroNorth and North 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: For HEDIS® 2012, the Virtual region reported a rate that was above the NCQA mean. HEDIS® Benchmarks for this measure were not available in Quality Compass 2014 due to changes in the measure specification.

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: For HEDIS® 2014, the Virtual region reported a rate that was above the NCQA mean for ages 21-24 years. All other regions/years were below the NCAA mean.

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: During all three measurement periods, all regions were below the NCAA mean except for HEDIS® 2014, the East region reported a rate that 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: The Southwest region was above the HEDIS® NCQA mean for 2012 and the Virtual region was above the HEDIS® NCQA mean for 2014.

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 for HEDIS® 2012-2014.

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. For HEDIS® 2014, the Southeast region was above the NCQA mean for Medical Attention for Nephropathy.

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 in 2013.

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 for HEDIS® 2012-2014.

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 HEDIS® 2012, North, East and Southeast were above the NCQA mean. For HEDIS® 2013, all regions but the Southwest were above the NCQA mean. For HEDIS® 2014, all regions but East, Southeast and 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® 2012-2014 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® 2012-2014, with the exception of the MetroNorth region for HEDIS® 2014.

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 four, five or 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 regions reported rates below the NCQA for HEDIS® 2012-2014.

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® 2012 and 2013 all regions reported both numerators above the NCQA mean with the exception San Juan and the West. For HEDIS® 2014, all regions reported both numerators above the NCQA mean with the exception of San Juan and Virtual for follow up 7 days, and Virtual for follow up 30 days.

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 Southeast region was 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: For HEDIS® 2013 and 2014, all regions with the exception of Virtual were above the NCQA mean for Engagement of AOD treatment ≥ 18 years old.

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 reported rates below the NCQA for HEDIS® 2012-2014.

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 for HEDIS® 2012-2014.

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: For HEDIS® 2012-2014, MetroNorth was above the NCQA mean for Any Services and Outpatient and ED. For HEDIS® 2014, all regions with the exception of Northeast and West were above the NCQA mean for Any Services and Outpatient and ED.

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 APS Healthcare and Triple-S Medicaid for the contract period 2013-2014. The assessment was conducted using methodology 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) PIPs submitted by APS Healthcare during the validation period.

APS Healthcare Medicaid PIP #1: Obesity and Depression 2013-2014

The aim of the PIP is to reduce depression screening scores on a formal depression screening tool (PHQ-9) for patients with depression and obesity who receive cognitive behavioral therapy via a telephonic psychotherapy program.

The objective of the PIP is to answer the following question:

- Will the use of cognitive behavioral therapy in patients with depression and obesity improve depressive symptoms?

Population

All members 18 years of age and older with a BMI greater than or equal to 30 and either a depression diagnosis or a PHQ-9 score equal to or greater than 10.

Indicators

- Identification of the population with obesity and depression.
- Increase the number of patients with those conditions receiving mental health services.
- Measure pre- and post-depressive symptoms. The stated goal is a greater than 5 point drop from baseline PHQ-9 score >10.
- Improve depressive symptoms.

Interventions

Member interventions:

- Enhance patient self-care by providing patient education, psychological services, monitoring and communication. The MCO will provide telephonic psychotherapy services using cognitive behavioral therapy and educational materials and will conduct follow-up to the patient.
- Facilitate member access to services including prevention services and prescription drugs as needed.

Data Analysis and Results

Not available. No baseline results were reported and the PIP report did not indicate when data would be available. This PIP was initiated in 2013-2014 and no results are reported as of 2015.

The PIP report states that members with a depression diagnosis (296.20-296.36) and members referred by the MCO and TPA will be included, but it is not clear how the MCO will identify members with BMI > 30 and members with PHQ-9 scores >10. The source of the BMI and PHQ-9 data is not stated.

Achievement of Improvement

Achievement of improvement cannot be determined, as no results were reported.

Strengths

Key strengths include:

- The rationale for the topic is supported by data and evidence-based findings that indicate there is a direct correlation between obesity and depression.

- The PIP's interventions involve regular provider contact with members over a period of time, which has the potential to improve depressive symptoms and/or obesity.

Opportunities for Improvement

Key opportunities for improvement include:

- In order to demonstrate relevance to the MCO's member population, the rationale for topic selection should include the rates for the co-morbid conditions depression and obesity among the MCO's population in addition to the evidence base presented.
- The MCO needs to clearly define the study indicators and data collection methodology.
- The stated objective to measure pre- and post-depressive symptoms is not fully explained. The MCO should fully describe the data collection process; i.e., how the PHQ-9 screener will be administered and scored for the target population.
- The MCO needs to provide a rationale for goal > 5 point decrease in PHQ-9 scores.
- Since the MCO is engaging members with obesity in this PIP and one goal of the PIP is to improve the rate of obesity among members with depression, the MCO should consider including an indicator to track BMI scores and a related performance goal with a supporting rationale.
- No baseline results are reported, although the PIP is dated 2013-2014. The MCO should provide the measurement results, set performance goals, and provide a rationale for each goal.
- The PIP should include a thorough barrier analysis linked to related interventions.
- The timeline for the interventions should be specific, including start and completion dates. Interventions should be identified as new or previously established.
- Details should be provided for each of the interventions. For example, the types of patient education and how education delivered (e.g., in-person, mail, telephone); how members will be assisted with access to care; how members will be assisted with filling prescriptions.
- Details should be provided regarding the telephonic therapy, e.g., types of providers, the type(s) of therapy services provided, and staff responsible for coordinating services.
- The effectiveness of the interventions should be evaluated at each measurement phase.
- Process indicators should be incorporated to track the effectiveness of the interventions. For example, for telephonic therapy: the number of members identified; the number of members outreached; the number engaged in therapy; the number completing the full 8 weeks of therapy.

Overall Credibility of Results

Not applicable. The MCO did not report baseline results nor did it state when these results would be available for review.

APS Healthcare Medicaid PIP #2: Well-Being for Members with Autism and ADHD 2013-2014

The aim of PIP is preventing maladaptive behaviors in members with autism and ADHD through parent education.

The objective of the PIP is to answer the following question:

- Does education on autism and ADHD well-being result in an increase in parent/family knowledge?

Population

All members ages 4 years and older with a claim for an outpatient and/or inpatient encounter dated on or before January 1st of the measurement year and a combination of diagnosis codes for autism and ADHD.

Indicators

- Patient self-care through patient education and communication.
- Communication and coordination among patients, physicians, MBHO and other providers.
- Access to services including prevention services and prescription drugs as needed.

Interventions

Member Interventions:

- Provide patient and family education to facilitate development and learning, promote socialization, and reduce maladaptive behaviors.
- Educate families and guide them toward behavior modification via follow-up calls, mailings and educational materials.
- Improve access to services including prevention services and prescription drugs as needed.

Provider Interventions:

- Improve communication and coordination of services among patients, physicians, MBHO and other providers.

Data Analysis and Results

Not available. No baseline results were reported, the data sources were not stated, and the PIP report did not indicate when data would be available. This PIP was initiated in 2013-2014 and no results are reported as of 2015.

Achievement of Improvement

Achievement of improvement cannot be determined, as no results were reported.

Strengths

Key strengths include:

- The intent of the PIP is to improve the health and quality of life for children with dual-diagnoses of autism and ADHD and their families.
- The study population defined using age criteria, diagnosis codes, and dates of service.

Opportunities for Improvement

Key opportunities for improvement include:

- The topic selection should be supported by data, e.g., national and/or local statistics, health services research and literature; evidence-based care guidelines, and MCO-specific data.
- The rationale should include MCO-specific data that support the relevance to the MCO's member population. For example, data on the prevalence of autism and ADHD among the MCO's members; costs (financial and health related) of maladaptive behavior; the proportion of these members who have claims for preventive services (compared to national averages and the overall member population).
- The study question should be revised to clearly define in measurable terms what the PIP is intended to measure and improve and a related indicator needs to be developed. The statement "an increase in knowledge of the families" is not measurable and the stated indicators do not specifically address this.
  The PIP describes scores for pre-test, 3 month and discharge evaluations to assess the effectiveness of the member/family education; however, no details about the evaluation tool are provided. The MCO needs to provide details on the specific education and testing components to clearly define the strategies being taught on preventing maladaptive behaviors and how comprehension will be assessed.
- The other indicators need to be clearly and fully defined in measureable terms:
  - "Patient self-care through patient education and communication." The MCO needs to define the aspects of self-care are being taught and how learning will be measured.
  - "Communication and coordination among patients, physicians, MBHO and other providers." The MCO needs to define communication and coordination and how these will be measured.
  - "Access to services including prevention services and prescription drugs as needed." The MCO needs to define the specific prevention services and what identified what indicates access to prescription drugs and how these will be measured.
- The MCO needs to describe the data sources and data collection methods for each of the indicators, e.g., claims, medical records, pre- and post-tests, surveys. It appears that the MCO intends to collect encounters for visits, services, and procedures; pharmacy claims for prescriptions; and referral and authorization data; and results of pre- and post-tests.
- The MCO needs to set quantitative performance goals for each of the indicators and provide a rationale for selecting these goals.
- No baseline results are reported, although the PIP is dated 2013-2014. The MCO should provide the measurement results, set performance goals, and provide a rationale for each goal.

- The PIP should include a thorough barrier analysis linked to related interventions.
- The timeline for the interventions should be specific, including start and completion dates. Interventions should be identified as new or previously established.
- Details should be provided for each of the interventions. For example, the types of parent education and how education delivered (e.g., in-person, mail, telephone); how members will be assisted with access to care; how members will be assisted with filling prescriptions.
- The effectiveness of the interventions should be evaluated at each measurement phase.
- Process indicators should be developed to track the effectiveness of the interventions. For example, for parent education: the number of parents identified; the number of parents outreached; the number engaged in education; the number of pre-tests completed, the number completing the full education program, the number of post-tests completed.

Overall Credibility of Results
Not applicable. The MCO did not report baseline results nor did it state when these results would be available for review.

Triple-S Medicaid Managed Care
Performance Improvement Project(s)

The following narrative summarizes the PIPs submitted by Triple-S Medicaid and IPRO's validation results.

Triple-S Medicaid PIP #1: Appropriate Medication Treatment for Members with Severe Asthma

The aim of the PIP is to improve care for members with severe asthma, including appropriate medications, flu vaccines, and utilization of services.

The objective of the PIP is to answer the following questions:

- Principal Question: Do members with severe asthma that participate in the MCO's Disease Management program receive the appropriate asthma medication?
- Do members with severe asthma that participate in the MCO's Disease Management program receive an annual influenza vaccine?
- Do members with severe asthma that participate in the MCO's Disease Management program have fewer outpatient visits for asthma exacerbations?
- Do members with severe asthma that participate in the MCO's Disease Management program have fewer ER visits for asthma exacerbations?
- Do members with severe asthma that participate in the MCO's Disease Management program have fewer hospitalizations for asthma exacerbations?

Population:
All members ages 5-56 years old who are identified as having severe asthma and who are actively participating in the MCO's Disease Management program.

Indicators
Clinical Indicators:

- Use of appropriate medications for asthma
- Influenza vaccine rate

Utilization Indicators:

- Outpatient visits for asthma exacerbation
- ER visits for asthma exacerbation
- Hospitalizations for asthma exacerbation

Interventions

Provider interventions:

- Provided continuing education programs and published provider magazine topics related to appropriate medication and management for people with asthma.

Member interventions:

- Sent welcome packets with information about asthma, the benefits of the appropriate medications, how to prevent exacerbations, and other topics.
- Coordinated educational workshops and Health Fair presentations that address the management of asthma.
- Disease Management nurses conducted telephone outreach to provide individualized asthma management guidelines to members.
- Develop and individualized treatment plan for each of the members with severe asthma who are enrolled in the Disease Management program.

Data Analysis and Results

The MCO reported that 247 members were active in the Disease Management program during all measurement periods. Baseline and interim results are shown in **Table 13.**

Table 13: Triple-S 2014 PIP – Appropriate Medication for Members with Asthma

Indicator	Baseline Rate Jun 2013	Quarterly Results				Change from Baseline	Goal
		Sep 2013	Dec 2013	Mar 2014	Jun 2014		
Clinical Indicators[1]							
Use of appropriate medications for asthma	99%	92%	89%	86%	86%	↓13% Goal Not Met	↑3% annually
Influenza vaccines	14%	23%	31%	29%	27%	↑93% Goal Met	↑3% annually
Utilization Indicators[2]							
Outpatient visits	504	482	498	451	399	↓105	N/A
Percentage change vs. previous quarter	N/A	↓4%	↑3%	↓9%	↓12%	Goal Met 3 of 4 quarters	↓1% quarterly
Percentage change vs. baseline	N/A	↓4%	↓2%	↓11%	↓21%	Goal Met	↓4% annually
ER visits	165	168	158	151	136	↓29	N/A
Percentage change vs. previous quarter	N/A	↑2%	↓6%	↓4%	↓10%	Goal Met 3 of 4 quarters	↓1% quarterly
Percentage change vs. baseline	N/A	↑2%	↓4%	↓9%	↓18%	Goal Met	↓4% annually
Hospitalizations	94	84	73	46	39	↓55	N/A
Percentage change compared to previous quarter	N/A	↓11%	↓13%	↓37%	↓15%	Goal Met	↓1% quarterly
Percentage change compared to baseline	N/A	↓11%	↓22%	↓51%	↓59%	↓59%	↓4% annually

N/A = not applicable; ↑increase ↓ decrease

[1] An increased rate represents improvement.

[2] A decreased rate represents improvement.

Achievement of Improvement

Clinical Indicators:

The goal for the clinical indicators was an increase of 3% annually. MCO reported that the final rate for use of appropriate asthma medications (86%) was a decrease of 13 percentage points (13%) compared to baseline (99%) and did not meet the goal of 3% improvement annually. The rate declined consistently each quarter. Conversely, the MCO reported that the final rate for influenza vaccines (27%) was an increase of 13 percentage points (93%) compared to baseline (14%) and exceeded the goal of 3% improvement annually.

Utilization Indicators:

The goal for the Utilization indicators was a decrease of 1% each quarter (4% annually). The final rates for each of the three utilization indicators (outpatient, ER and hospitalizations) declined compared to baseline (21%, 18%, and 59%, respectively) and exceeded the goal.

Strengths

Key strengths include:

- The topic selected, appropriate treatment of asthma, provides can result in significant changes in members' health and quality of life as well as financial savings.
- The MCO made direct member contacts and provided individualized care.
- The MCO collected comparable data for the baseline and interim periods, using industry standard codes.
- The MCO reported baseline rates as well as four quarterly rates for each of the indicators.
- Results demonstrated overall improvement for flu vaccine rates and all utilization indicators (outpatient, ER visits, and hospitalizations for asthma exacerbation) for the population studied.

Opportunities for Improvement

Key opportunities for improvement include:

- The topic is not supported by a strong rationale and contains only references to American Lung Association recommendations and a general statement that people with severe asthma have high rates of ER and inpatient utilization. The rationale should include references to specific national, local or Medicaid statistics and health services research and literature.
- The rationale should demonstrate relevance to the MCO's member population through MCO-specific data including: the proportion of members with asthma and severe asthma, rates for appropriate medication use and utilization data for outpatient visits, ER visits, and inpatient utilization for asthma exacerbations.
- The rate for use of appropriate medication for asthma (99%) does not present an opportunity for improvement. The MCO should have identified this by looking at historical rates for the HEDIS® indicator for the overall population of members with severe asthma.
- As defined, the eligible member population for the PIP excludes the majority of members with asthma and therefore, the PIP is limited in scope and has little potential to make an impact on the overall member population's health. The PIP impacted 247 of the approximately 3,200 members eligible for the study which represents 7.7% of the eligible population.
- The indicator definition should include the criteria used to identify members with severe asthma.
- The PIP is biased toward improvement since it only focuses on members with severe asthma who receive Disease Management services.
- The MCO should have implemented interventions to address all members with severe asthma.
- The provider interventions were limited and passive, which could have contributed to the decline in appropriate medication use.
- The rate of appropriate medication use consistently declined over the course of the study. The MCO should have analyzed the downward trend of appropriate medication use, conducted a root-cause analysis, identified barriers, and developed and implemented specific and targeted interventions, rather than observe the continued decline.
- The PIP should incorporate process measures to track and evaluate the results of the interventions (i.e., number of members identified with severe asthma; number of members outreached; number enrolled in the Disease Management program).

Overall Credibility of Results
The validation findings generally indicate that the reported results are biased toward improvement since the member population was limited to those enrolled in disease management.

Triple-S Medicaid PIP #2: Blood Pressure Control and Cholesterol Screening for Members with Hypertension 2014

The aim of the PIP is to improve blood pressure control and cholesterol screening for members with severe hypertension.

The objective of the PIP was to answer the following questions:

- Does participation in the MCO's Disease Management program improve blood pressure control (defined as BP<140/90mmHg) for members with severe hypertension?
- Does participation in the MCO's Disease Management program improve the rate of cholesterol screening (defined as an LDL-C test) during the measurement year for members with severe hypertension?
- Does participation in the Disease Management program decrease the rate of outpatient visits for complications of hypertension for members with severe hypertension?
- Does participation in the Disease Management program decrease the rate of ER visits for complications of hypertension for members with severe hypertension?
- Does participation in the Disease Management program decrease the rate of hospitalizations for complications of hypertension for members with severe hypertension?

Indicators
Clinical Indicators:

- HEDIS® Controlling High Blood Pressure (CBP)
- HEDIS® Cholesterol Management for People with Cardiac Conditions (CMC)
- (modified to LDL Screening for members with hypertension only)

Utilization Indicators:

- Outpatient visits for complications of hypertension
- ER visits for complications of hypertension
- Hospitalizations for complications of hypertension

Study Population
All members aged 18-75 years old with severe hypertension that are actively participating in the MCO's Disease Management Program.

Members are excluded if there is a diagnosis of End Stage Renal Disease during, or prior to the measurement year or a diagnosis of pregnancy during the measurement year.

Interventions
Provider interventions:

- Promote the use of evidence based guidelines for hypertension via the provider portal.
- Provide continuing education activities and publish provider magazine topics related to appropriate care for hypertension.

Member interventions:

- Send Welcome packets with information about hypertension, the benefits of controlled blood pressure, common complications of hypertension, and other topics.
- Coordinate educational workshops and Health Fair presentations that address care for hypertension.
- Disease Management nurses conduct telephone outreach to provide individualized guidelines to members.
- Develop an individualized treatment plan for each of the members with severe hypertension enrolled in the Disease Management program.

Data Analysis and Results
The MCO reported that there were 241 members with severe hypertension who were active in the Disease Management program during all measurement periods.

Baseline and interim results are shown in **Table 14**.

Table 14: Triple-S 2014 PIP – Control of High Blood Pressure and Cholesterol Screening for Members with Severe Hypertension

Indicator	Quarterly Results					Final Rate vs. Baseline	Goal
	Jun 2013	Sep 2013	Dec 2013	Mar 2014	Jun 2014		
Clinical Indicator[1]							
Blood Pressure controlled	81%	89%	80%	71%	2%[3]	↓ 12%[4] Goal Not Met	↑3% annually
LDL-C screening[5]	119	125	124	127	122	↑2.5% Goal Not Met	↑3% annually
Utilization Indicator[2]							
Outpatient visits	822	786	754	713	635	↓187	N/A
Percentage change vs. previous quarter	N/A	↓4%	↓4%	↓5%	↓11%	Goal Met 4 of 4 quarters	↓1% quarterly
Percentage change vs. baseline	N/A	↓4%	↓8%	↓13%	↓23%	↓23% Goal Met	↓4% annually
ER visits	198	148	108	105	66	↓132	N/A
Percentage change vs. previous quarter	N/A	↓25%	↓27%	↓3%	↓37%	Goal Met 4 of 4 quarters	↓1% quarterly
Percentage change vs. baseline	N/A	↓25%	↓45%	↓47%	↓67%	↓18% Goal Met	↓4% annually
Hospitalizations[6]	4	4	4	4	3	↓1	N/A
Percentage change vs. previous quarter	N/A	No change	No change	No change	↓25%	Goal Met 1 of 4 quarters	↓1% quarterly
Percentage change vs. baseline	N/A	No change	No change	No change	↓25%	↓25% Goal Met	↓4% quarterly

N/A = not applicable; ↑increase ↓ decrease
[1] An increased rate represents improvement.
[2] A decreased rate represents improvement.
[3] The MCO reported difficulty obtaining data for this measurement period.
[4] Represents change from baseline to quarter 1 2014.
[5] The MCO reported whole numbers (number of tests?). A percentage should be reported for this indicator.
[6] Results should be interpreted with caution due to small numbers.

Achievement of Improvement
The goal for both clinical indicators was an increase of 3% annually.

The final rate reported for blood pressure controlled was 2%; however, the MCO reported data collection difficulties. The baseline rate was 81%. The rate fluctuated quarterly, with a result of 71% for the third measurement period (quarter 1 2014), representing a decrease of 12% for the year.

The MCO reported whole numbers for LDL-C screening indicator. The indicator should be reported as a percentage. The final rate reported for LDL-C screening was 122 compared to the baseline rate of 119. This represents an increase of 2.5% over baseline which fell short by 0.5 percentage points of the goal of a 3% annual increase. The quarterly results for the measure exceeded baseline results during every quarter reported. The results for this measure should be interpreted with caution, since the rate should be a percentage, not a whole number.

The goal for the Utilization indicators was a decrease of 1% quarterly. The outpatient and ER visit indicators improved and met or exceeded the goal consistently each quarter. The hospitalization rate remained flat at 4 per quarter in all measurement periods except for the June 2014, with a rate of 3 hospitalizations. The goal was achieved for one of four quarters.

Strengths
Key strengths include:

- The MCO used administrative data and the same methodology for all quarterly measurement periods.
- The interventions implemented addressed the barriers identified.
- The MCO achieved improvement for some indicators.

Opportunities for Improvement
Key opportunities for improvement include:

- The MCO should support the topic selection with national or local data or references health services literature.
- The MCO should support the topic's relevance to the MCO's membership by presenting related member demographic and utilization data.
- The MCO should define the criteria used to classify a member with severe hypertension.
- The MCO should describe the data collection difficulties that led to the result of 2% in June 2014. The MCO should not report the invalid rate.
- The MCO should track the progress of the interventions (i.e., number of outreach attempts, number of members contacted, number providers educated) in order to evaluate the success of the interventions relative to achieving or failure to achieve improvement.
- The PIP only impacted 241 of the 2,359 members eligible for the study which represents 10.2% of the eligible population. The PIP should address the entire eligible population.

Overall Credibility of Results
The validation findings generally indicate that the reported results are biased toward improvement since the member population was limited to those enrolled in disease management.

Triple-S Medicaid PIP #3: Screening for Diabetics – HbA1c Testing and Eye Exam

The aim of the PIP is to improve members' control of their diabetes resulting in a decrease in complications (e.g., diabetic retinopathy) and utilization as a result of complications (e.g., fewer outpatient visits, Emergency Room (ER) visits and hospitalizations).

The objective of the PIP is to answer the following questions:

- Will participation in the in the MCO's Disease Management Program increase the rate of annual HbA1c testing for Medicaid members with severe diabetes?
- Will participation in the in the MCO's Disease Management Program increase the rate annual dilated fundoscopic eye exams for Medicaid members with severe diabetes?
- Will participation in the in the MCO's Disease Management Program result in fewer outpatient visits for complications of diabetes for Medicaid members with severe diabetes?
- Will participation in the in the MCO's Disease Management Program result in fewer ER visits for complications of diabetes for Medicaid members with severe diabetes?
- Will participation in the in the MCO's Disease Management Program result in fewer hospitalizations for complications of diabetes for Medicaid members with severe diabetes?

Indicators
Clinical Indicators:

- HEDIS® Comprehensive Diabetic Care (CDC): HbA1c testing
- HEDIS® Comprehensive Diabetic Care (CDC): Retinal Eye Exam

Utilization Indicators:

- Outpatient visits for complications of diabetes
- ER visits for complications of diabetes
- Hospitalizations for complications of diabetes

Study Population

All members aged 18-75 years old with severe diabetes that are actively participating in the MCO's Disease Management Program. Female members with a diagnosis Polycystic Ovaries are excluded.

Members are excluded if there is a diagnosis of End Stage Renal Disease during, or prior to the measurement year or a diagnosis of pregnancy during the measurement year.

Interventions

Provider interventions:

- Promote the use of evidence based guidelines for diabetes via the provider portal.
- Provide continuing education activities and publish provider magazine topics related to appropriate care for members with diabetes.

Member interventions:

- Send Welcome packets with information about diabetes, the benefits of blood sugar control, common complications of diabetes, and other topics.
- Send member reminders for necessary screening tests.
- Coordinate educational workshops and Health Fair presentations that address care for diabetes.
- Disease Management nurses conduct telephone outreach to provide individualized guidelines to members.
- Develop an individualized treatment plan for each of the members with severe diabetes enrolled in Disease Management program.

Data Analysis and Results

The MCO reported that 1,108 members were active in the Disease Management Program during all measurement periods.

Baseline and interim results are shown in **Table 15**.

Table 15: Triple-S 2014 PIP – Screening for Members with Diabetes: HbA1c Testing and Eye Exam

Quarterly Results							
Indicator	Jun 2013	Sep 2013	Dec 2013	Mar 2014	Jun 2014 Final	Final Rate vs. Baseline	Goal
Clinical Indicator[1]							
CDC – HbA1c test rate[3]	726	706	719	713	678	↓7% Goal Not Met	↑3% annually
CDC – Eye exam performed[3]	198	219	235	241	246	↑24% Goal Met	↑3% annually
Utilization Indicator[2]							
Outpatient visits	3,590	3,626	3,688	3,577	3,356	↓234	N/A
Percentage change vs. previous quarter	N/A	↑1%	↑2%	↓3%	↓6%	Goal Met 2 of 4 quarters	↓1% quarterly
Percentage change vs. baseline	N/A	↑1%	↑3%	↓0.4%	↓7%	↓7% Goal Met	↓4% annually

Quarterly Results							
Indicator	Jun 2013	Sep 2013	Dec 2013	Mar 2014	Jun 2014 Final	Final Rate vs. Baseline	Goal
ER visits	116	115	107	96	88	↓28	N/A
Percentage change vs. previous quarter	N/A	↓1%	↓7%	↓10%	↓8%	Goal Met 4 of 4 quarters	↓1% quarterly
Percentage change vs. baseline	N/A	↓1%	↓8%	↓17%	↓24%	↓24% Goal Met	↓4% annually
Hospitalizations	64	55	44	39	36	↓28	N/A
Percentage change vs. previous quarter	N/A	↓15%	↓20%	↓11%	↓8%	Goal Met 4 of 4 quarters	↓1% quarterly
Percentage change vs. baseline	N/A	↓15%	↓31%	↓39%	↓44%	↓44% Goal Met	↓4% annually

N/A= not applicable; ↑increase ↓ decrease

[1] An increased rate represents improvement.

[2] A decreased rate represents improvement.

[3] The MCO reported whole numbers (number of tests?). A percentage should be reported for this indicator.

Achievement of Improvement

The goal for both Clinical indicators was an increase of 3% annually.

The final rate reported rate for HbA1c testing was 678; however, the rate should be reported as a percentage, not a whole number. Assuming that the reported numbers represent number of tests, the rate decreased by 48 or 7% compared to baseline. The MCO did not meet the goal of a 3% increase annually.

The final rate reported rate for eye exams was 246; however the rate should be reported as a percentage, not a whole number. Assuming that the reported numbers represent number of exams, overall, the rate increased by 48 or 24% compared to baseline. The MCO exceeded the goal of a 3% increase annually.

The goal for the utilization indicators was a decrease of 1% quarterly (or 4% annually).

The outpatient visits increased in the first two quarters and then decreased below the baseline in the second two quarters. The final rate was a decrease of 234 or 7% compared to baseline. The MCO exceeded the goal of a 4% decrease annually.

The ER visits decreased each quarter consistently. The final reported rate was 88. Overall, the number of visits decreased by 28 or 24% compared to baseline. The MCO exceeded the goal of a 4% decrease annually.

The hospitalizations decreased each quarter consistently. The final reported rate was 36. Overall, the number of visits decreased 28 or 44% compared to baseline. The MCO exceeded the goal of a 4% decrease annually.

Strengths

Key strengths include:

- The MCO used administrative data and the same methodology for all quarterly measurement periods.
- The interventions implemented addressed the barriers identified.
- The MCO achieved improvement for some indicators.

Opportunities for Improvement

Key opportunities for improvement include:

- The MCO supported the topic selection based up a reference to the American Diabetes Association recommendations for HbA1c testing and retinal eye exams. However, the MCO should reference relevant national or local data or health services literature.
- The MCO should support the topic's relevance to the MCO's membership by presenting related member demographic and utilization data.
- The MCO should define the criteria used to classify a member with severe diabetes.
- The MCO should track the progress of the interventions (i.e., number of outreach attempts, number of members contacted, number providers educated) in order to evaluate the success of the interventions relative to achieving or failure to achieve improvement.
- The number of HbA1c tests decreased consistently each quarter during the project. When rates decline, the MCO should evaluate the interventions and revise the interventions rather than allowing the rate to continually decline.
- The PIP impacted only 1,108 of the 3,353 members eligible for the study which represents 33% of the eligible population. The PIP should address the entire eligible population.

Overall Credibility of Results

The validation findings generally indicate that the reported results are biased toward improvement since the member population was limited to those enrolled in disease management.

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 2013-2014 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: 2013-2014 Quality Improvement Project (QIP)
Validation of PMs: HEDIS® 2014 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 CY2014 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 2014. The information is derived from IPRO's conduct of the annual compliance reviews in August/September 2015. 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) 2015 Medicare Compliance Review Findings for Contract Year 2014

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 found minimally or non-compliant. Assessment of the effectiveness of the plan's progress for elements found non-compliant in the prior review follows the 2015 findings.

Table 16: AHM – Summary of 2015 MMC Compliance Review Findings

AHM: Summary of 2015 Medicare Managed Care Compliance Review Findings (Review Year 2014)					
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	44	4	0	0
Enrollee Rights and Protections	49	47	2	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	45	45	0	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	32	26	5	1	0

Table 17: AHM – 2015 MMC Compliance Review: Minimal and Non-Compliant Elements

AHM: Summary of 2015 Medicare Managed Care Compliance Review Findings Minimal and Non-Compliant (Review Year 2014)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	▪ All applicable requirements were Compliant.*
Enrollee Rights and Protections	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Access	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ Consider the needs of the MCO's enrollees. **Minimal Compliance:** The MCO should update Policies and Procedures to detail how the needs of enrollees are considered in adopting or developing clinical guidelines.

*Compliance is defined as having Full or Substantial Compliance.

Table 18: AHM – 2015 MMC Compliance Review: Follow-Up for Previous Minimal and Non-Compliant Elements

AHM: 2015 Medicare Managed Care Compliance Review – Follow-Up for Elements Minimal and Non-Compliant in 2013 Review (Review Year 2012-2013)	
Description of Review Findings Minimal and Non-Compliant	**Follow-Up Findings: Current Status**
Standard: Grievance System	
Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. **Minimal Compliance:** Ensure that appeal acknowledgement letters inform the enrollee of the right to present evidence in writing and in person.	▪ 2015 Review Determination: **Substantial Compliance**
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:** Ensure that appeals acknowledgement letters contain 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.	▪ 2015 Review Determination: **Substantial Compliance**
Enrollee Rights and Protections	
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:** Ensure that the following is communicated to members: 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.	▪ 2015 Review Determination: **Substantial Compliance**
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:** Ensure that P/P addresses correcting or amending medical records.	▪ 2015 Review Determination: **Full Compliance**
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…and its providers or the State agency treat the enrollee. **Minimal Compliance:** Ensure that the EOC and Provider Manual address that each enrollee is free to exercise rights, and that the exercise of rights does not adversely affect the way the MCO…its providers or the State agency treat the enrollee.	▪ 2015 Review Determination: **Full Compliance**

AHM: 2015 Medicare Managed Care Compliance Review – Follow-Up for Elements Minimal and Non-Compliant in 2013 Review (Review Year 2012-2013)	
Description of Review Findings Minimal and Non-Compliant	**Follow-Up Findings: Current Status**
Quality Assessment and Performance Improvement (QAPI) – Access	
Each MCO… must implement mechanisms to assess each Medicaid enrollee identified by the State 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:** Ensure that all CM files contain an assessment.	▪ 2015 Review Determination: **Full Compliance**
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:** Ensure that treatment plans are comprehensive.	▪ 2015 Review Determination: **Full Compliance**
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. **Minimal Compliance:** Ensure that all recredentialing is conducted timely; that dates are documented in the file; that evidence of primary source verification of the provider's work history or residency/post-grad internship is conducted and maintained in the file; that the provider signature attesting to the completeness and truth of the application is not sufficient to verify the work history/post-grad internship.	▪ 2015 Review Determination: **Full Compliance**
Members may choose to disenroll for cause. **Minimal Compliance:** Ensure that P/P addresses all allowable reasons for a member to disenroll.	▪ 2015 Review Determination: **Full Compliance**
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	
Are reviewed and updated periodically as appropriate. **Minimal Compliance:** Ensure that there is evidence that guidelines are reviewed and updated annually (e.g., discussion of CPGs in the QMC, UCMAC and MMC is evident.	▪ 2015 Review Determination: **Full Compliance**
Ensure that data received from providers is accurate and complete. **Minimal Compliance:** Ensure that P/P address validating provider and vendor submitted data and for internal quality measurement and that documentation of validation of accuracy and completeness of encounter data, including "analysis and follow-up" is maintained.	▪ 2015 Review Determination: **Full Compliance**
Verifying the accuracy and timeliness of reported data. **Minimal Compliance:** Ensure that P/P address validating provider and vendor submitted data and for internal quality measurement and that documentation	▪ 2015 Review Determination: **Full Compliance**

AHM: 2015 Medicare Managed Care Compliance Review – Follow-Up for Elements Minimal and Non-Compliant in 2013 Review (Review Year 2012-2013)	
Description of Review Findings Minimal and Non-Compliant	**Follow-Up Findings: Current Status**
of validation of accuracy and completeness of encounter data, including "analysis and follow-up" is maintained.	
Screening the data for completeness, logic, and consistency. **Minimal Compliance:** Ensure that P/P address validating provider and vendor submitted data and for internal quality measurement and that documentation of validation of accuracy and completeness of encounter data, including "analysis and follow-up" is maintained.	▪ 2015 Review Determination: **Full Compliance**
Collecting service information in standardized formats to the extent feasible and appropriate. **Minimal Compliance:** Ensure that P/P address validating provider and vendor submitted data and for internal quality measurement and that documentation of validation of accuracy and completeness of encounter data, including "analysis and follow-up" is maintained.	▪ 2015 Review Determination: **Full Compliance**

Constellation 2015 Medicare Compliance Review Findings for Contract Year 2014

A summary of the Medicare compliance results for Constellation is provided below. For each standard, the following is provided: current year overall category compliance designations; a description of the current year findings for all standards/elements found minimally or non-compliant. Assessment of the effectiveness of the plan's progress for elements found non-compliant is not provided, as this was the first review. IPRO will assess the effectiveness of the plan's corrective actions during the next annual compliance review.

Table 19: Constellation – Summary of 2015 MMC Compliance Review Findings

Constellation: Summary of 2015 Medicare Managed Care Compliance Review Findings (Review Year 2014)					
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	28	11	8	1
Enrollee Rights and Protections	49	49	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	46	36	2	4	4
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	21	13	3	0	5
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	19	6	3	3	7

Table 20: Constellation – 2015 MMC Compliance Review: Minimal and Non-Compliant Elements

Constellation: 2015 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	▪ Notice of action; the notice must be in writing and must meet the language and format requirements and to ensure ease of understanding. **Minimal Compliance:** UM Files should contain the notice of action/denial letter and be written in a format and language that is easily understood by the member. ▪ The action the MCO or PIHP or its contractor has taken or intends to take. **Minimal Compliance:** UM Files should include the action take or intended to be taken in the notice of action. ▪ The reasons for the action. **Minimal Compliance:** UM Files should include the reasons for the action in the notice of action. ▪ The enrollee's or the provider's right to file and MCO or PIHP appeal. **Minimal Compliance:** UM Files should include the member's right to file an appeal in the notice of action. ▪ If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing. **Minimal Compliance:** UM Files should include the member's right to request a state fair hearing or how to do so. ▪ The Procedures for exercising these rights. **Minimal Compliance:** UM Files should include the member's right to request a State fair hearing or how to do so. ▪ The circumstances under which expedited resolution is available and how to request it. **Minimal Compliance:** UM Files should include a notice of action/denial letter. ▪ The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services. **Minimal Compliance:** UM Files should include the member's right to continue benefits. ▪ The MCO or PIHP must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an appeal. **Non-Compliance:** The Appeal policy should include this requirement and should also be communicated to the provider in either the Provider Manual or the Provider Contract.
Enrollee Rights and Protections	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Access	▪ Each MCO…must implement mechanisms to assess each Medicaid enrollee identified by the State and MCO…by the state as having special health care needs in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. **Minimal Compliance:** Care Management Files should include an assessment. ▪ Consult with the requesting provider when appropriate. **Minimal Compliance:** UM Files should include evidence of consultation. ▪ Any decision to deny a service authorization request, authorize a service in an amount, or duration or scope that is less than requested, be made by the authorized health care professional with appropriate clinical expertise. **Minimal Compliance:** UM Files should include qualifications of the MCO reviewer.

Constellation: 2015 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
	▪ Notice of adverse action. **Minimal Compliance:** UM Files should include a notice of action/denial letter. ▪ Specify what constitutes "medically necessary services in a manner that…**Non-Compliance:** The MCO should provide documentation to meet this requirement. ▪ Compensation of utilization management activities. **Non-Compliance:** The MCO should provide documentation to meet this requirement. ▪ If the State requires 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, the treatment plan must be…**Non-Compliance:** Care Management Files should include a treatment plan. ▪ …developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee… **Non-Compliance:** Care Management Files should include a treatment plan.
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ Provide that the MCO… may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. **Non-Compliance:** Revised Policies and Procedures on Disenrollment should be provided. ▪ Specify the methods by which the MCO… assures the agency that it does not request disenrollment for reasons other than those permitted under the contract. **Non-Compliance:** The MCO should update corresponding Policies and Procedures with the required language. ▪ Disenrollment requested by the enrollee; for any cause, at any time. **Non-Compliance:** The MCO should update the policy with the required language. ▪ Disenrollment requested by the enrollee; without cause, at the following times…**Non-Compliance:** The MCO should update the policy with the required language. ▪ An MCO… may either approve a request for disenrollment or refer the request to the State…If the MCO… or State agency fails to make a disenrollment determination so that the recipient can be disenrolled within the timeframes, the disenrollment is considered approved. **Non-Compliance:** The MCO should update the policy with the required language.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ Consider the needs of the MCO's…enrollees. **Minimal Compliance:** The MCO should describe its process for assessing member needs in order to identify areas needing development of adoption of guidelines. ▪ The State must require, through its contracts that each MCO… have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. **Minimal Compliance:** The MCO should develop an annual QI Work Plan that includes yearly planned activities and related.

Constellation: 2015 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
	▪ Collect data on enrollee and provider characteristics as specified by the State…**Minimal Compliance:** The MCO should develop and provide Policies and Procedures for collecting and processing claims and encounter data. ▪ The State must review, at least annually, the impact and effectiveness of each MCO's…quality assessment and performance improvement program. **Non-Compliance:** The MCO should complete the 2014 Program Evaluation. ▪ The State may require that an MCO have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. **Non-Compliance:** The MCO should complete the 2014 Program Evaluation. ▪ Ensure that data received from providers is accurate and complete…**Non-Compliance:** Policies and Procedures for monitoring data for completeness and accuracy should be provided. ▪ Verifying the accuracy and timeliness of reported data. **Non-Compliance:** Policies and Procedures for monitoring data for completeness and accuracy should be provided. ▪ Screening the data for completeness, logic and consistence. **Non-Compliance:** Policies and Procedures for monitoring data for completeness and accuracy, such as the application of edits, should be provided. ▪ Collecting service information in standardized formats to the extent feasible and appropriate. **Non-Compliance:** Policies and Procedures for collecting service information in standardized formats should be provided. ▪ Make all collected data available to the Sate and upon request to CMS, as required. **Non-Compliance:** Evidence of submission of data to the State should be provided.

*Compliance is defined as having Full or Substantial Compliance.

First Plus 2015 Medicare Compliance Review Findings for Contract Year 2014

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 found minimally or non-compliant. Assessment of the effectiveness of the plan's progress for elements found non-compliant in the prior review follows the 2015 findings.

Table 21: First Plus – Summary of 2015 MMC Compliance Review Findings

First Plus: Summary of 2015 Medicare Managed Care Compliance Review Findings (Review Year 2014)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	48	47	1	0	0
Enrollee Rights and Protections	49	49	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	45	45	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	21	21	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	32	32	0	0	0

Table 22: First Plus – 2015 MMC Compliance Review: Minimal and Non-Compliant Elements

First Plus: 2015 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	▪ All applicable requirements were Compliant.*
Enrollee Rights and Protections	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Access	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

Table 23: First Plus – 2015 MMC Compliance Review: Follow-Up for Previous Minimal and Non-Compliant Elements

First Plus: 2015 Medicare Managed Care Compliance Review – Follow-Up for Elements Minimal and Non-Compliant in 2013 Review (Review Year 2012–2013)	
Description of Review Findings Minimal and Non-Compliant	**Follow-Up Findings: Current Status**
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	
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:** The MCO should ensure that a P/P is in place, that there is evidence of the data collection, and that these are provided with the pre-onsite documentation.	▪ 2015 Review Determination: **Full Compliance**

Humana Health Plan (HHP) 2015 Medicare Compliance Review Findings for Contract Year 2014

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 found minimally or non-compliant. Assessment of the effectiveness of the plan's progress for elements found non-compliant in the prior review follows the 2015 findings.

Table 24: HHP – Summary of 2015 MMC Compliance Review Findings

Humana Health Plan: Summary of 2015 Medicare Managed Care Compliance Review Findings (Review Year 2014)					
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	47	0	0	0
Enrollee Rights and Protections	48	48	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	43	40	3	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	21	21	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	31	24	7	0	0

Table 25: HHP – 2015 MMC Compliance Review: Minimal and Non-Compliant Elements

Humana Health Plan: 2015 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	▪ All applicable requirements were Compliant.*
Enrollee Rights and Protections	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Access	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

Table 26: HHP – 2015 MMC Compliance Review: Follow-Up for Previous Minimal and Non-Compliant Elements

Humana Health Plan: 2015 Medicare Managed Care Compliance Review – Follow-Up for Elements Minimal and Non-Compliant in 2013 Review (Review Year 2012–2013)	
Description of Review Findings Minimal and Non-Compliant	**Follow-Up Findings: Current Status**
Standard: Grievance System	
Action following denial of a request for expedited resolution. **Minimal Compliance**: Humana should ensure that time frames in P/Ps are consistent and aligned with the requirements.	▪ 2015 Review Determination: **Full Compliance**
Enrollee Rights and Protections	
MCO…must give each enrollee written notice of any change (that the State defines as "significant") in the information…at least 30 days before the intended effective date of the change. **Non-Compliance:** Humana should provide written notice of any significant change at least 30 days before the intended change takes effect and should include this information in the EOC.	▪ 2015 Review Determination: **Full Compliance**
Quality Assessment and Performance Improvement (QAPI) – Access	
Any decision to deny a service authorization request or authorize in an amount, duration or scope less than requested be made by a health care professional with appropriate clinical expertise. **Minimal Compliance:** Humana should ensure that all the UM process and file documentation are consistent with MCO P/Ps and regulatory requirements and that the files contain evidence that the reviewer is a health care professional with appropriate clinical expertise.	▪ 2015 Review Determination: **Full Compliance**
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:** Humana should ensure that contracts provide that conduct UM functions is not structured so as to provide incentives to deny or limit medically necessary services and should develop a P/P to address incentives/lack of incentives for UM functions.	▪ 2015 Review Determination: **Full Compliance**

Medical Card Systems (MCS) 2015 Medicare Compliance Review Findings for Contract Year 2014

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 found minimally or non-compliant. Assessment of the effectiveness of the plan's progress for elements found non-compliant in the prior review follows the 2015 findings.

Table 27: MCS – Summary of 2015 MMC Compliance Review Findings

Medical Card Systems: Summary of 2015 Medicare Managed Care Compliance Review Findings (Review Year 2014)					
Standard	**Total Number of Elements**	**Number of Elements Scored Full Compliance**	**Number of Elements Scored Substantial Compliance**	**Number of Elements Scored Minimal Compliance**	**Number of Elements Scored Non-Compliance**
Grievance System	48	47	1	0	0
Enrollee Rights and Protections	48	46	2	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	44	44	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	21	18	2	0	1
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	31	31	0	0	0

Table 28: MCS – 2015 MMC Compliance Review: Minimal and Non-Compliant Elements

Medical Card Systems: 2015 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	▪ All applicable requirements were Compliant.*
Enrollee Rights and Protections	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Access	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	▪ Cause for Involuntary and Voluntary Disenrollment. **Non-Compliance:** This requirement is not addressed in the Member Handbook and the MCO should add the required language to the corresponding Policies and Procedures and Member Handbook.
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

Table 29: MCS – 2015 MMC Compliance Review: Follow-Up for Previous Minimal and Non-Compliant Elements

MCS: 2015 Medicare Managed Care Compliance Review – Follow-Up for Elements Minimal and Non-Compliant in 2013 Review (Review Year 2012–2013)	
Description of Review Findings Minimal and Non-Compliant	**Follow-Up Findings: Current Status**
Enrollee Rights and Protections	
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. **Minimal Compliance:** MCS should ensure it fully addresses the enrollee's general right to be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, under any circumstances in P/P, Member Handbook, and Provider Manual.	▪ 2015 Review Determination: **Full Compliance**

MMM 2015 Medicare Compliance Review Findings for Contract Year 2014

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 found minimally or non-compliant. Assessment of the effectiveness of the plan's progress for elements found non-compliant in the prior review is not presented as there were no requirements found non-compliant.

Table 30: MMM – Summary of 2015 MMC Compliance Review Findings

MMM: Summary of 2015 Medicare Managed Care Compliance Review Findings (Review Year 2014)					
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	48	0	0	0
Enrollee Rights and Protections	49	49	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	45	45	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	21	21	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	32	32	0	0	0

Table 31: MMM – 2015 MMC Compliance Review: Minimal and Non-Compliant Elements

MMM: 2015 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014)	
Standard	**Description of Review Findings Not Fully Compliant**
Grievance System	▪ All applicable requirements were Compliant.*
Enrollee Rights and Protections	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Access	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) –Measurement and Improvement	▪ All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

PMC 2015 Medicare Compliance Review Findings for Contract Year 2014

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 found minimally or non-compliant. Assessment of the effectiveness of the plan's progress for elements found non-compliant in the prior review is not presented as there were no requirements found non-compliant.

Table 32: PMC – Summary of 2015 MMC Compliance Review Findings

PMC: Summary of 2015 Medicare Managed Care Compliance Review Findings (Review Year 2014)					
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	46	1	0	0
Enrollee Rights and Protections	49	49	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	45	45	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	21	21	0	0	0
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	32	32	0	0	0

Table 33: PMC – 2015 MMC Compliance Review: Minimal and Non-Compliant Elements

PMC: 2015 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	▪ All applicable requirements were Compliant.*
Enrollee Rights and Protections	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Access	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ All applicable requirements were Compliant.*

*Compliance is defined as having Full or Substantial Compliance.

Triple-S 2015 Medicare Compliance Review Findings for Contract Year 2014

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 found minimally or non-compliant. Assessment of the effectiveness of the plan's progress for elements found non-compliant in the prior review follows the 2015 findings.

Table 34: Triple-S – Summary of 2015 MMC Compliance Review Findings

Triple-S: Summary of 2015 Medicare Managed Care Compliance Review Findings (Review Year 2014)					
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	49	45	3	0	0
Quality Assessment and Performance Improvement (QAPI) – Access	45	44	0	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	32	26	5	1	0

Table 35: Triple-S – 2015 MMC Compliance Review: Minimal and Non-Compliant Elements

Triple-S: 2015 Medicare Managed Care Compliance Review – Elements Minimal and Non-Compliant (Review Year 2014)	
Standard	**Description of Review Findings Minimal and Non-Compliant**
Grievance System	▪ All applicable requirements were Compliant.*
Enrollee Rights and Protections	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Access	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) –Structure and Operations	▪ All applicable requirements were Compliant.*
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	▪ Consider the needs of the MCO's…enrollees. **Minimal** - Triple-S should update the P/Ps to detail how the needs of enrollees are considered in adopting or developing clinical

*Compliance is defined as having Full or Substantial Compliance.

Triple S: 2015 Medicare Managed Care Compliance Review – Follow-Up for Elements Minimal and Non-Compliant in 2013 Review (Review Year 2012-2013)	
Description of Review Findings Minimal and Non-Compliant	**Follow-Up Findings: Current Status**
Standard: Grievance System	
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:** Triple S should ensure that information about the grievance system, as required, is provided to all providers and subcontractors at the time they enter into a contract.	▪ 2015 Review Determination: **Full Compliance**
Enrollee Rights and Protections	
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:** Triple S should ensure that the all wording is consistent between the Provider Directory and MCO policies. Triple S should clarify which statement is correct regarding providers accepting new members.	▪ 2015 Review Determination: **Substantial Compliance**
The MCO has written policies regarding the enrollee rights: the right to Information on physician incentive plans. **Minimal Compliance:** Triple S should ensure that information on physician incentives (if any) or the lack of physician incentives is communicated to members.	▪ 2015 Review Determination: **Substantial Compliance**
Quality Assessment and Performance Improvement (QAPI) – Structure and Operations	
MCO… assures the agency that it does not request disenrollment for reasons other than those permitted under the contract. **Minimal Compliance:** Triple S Platino should ensure that reports of disenrollment are provided to ASES and documentation of submission is maintained.	▪ 2015 Review Determination: **Full Compliance**
Quality Assessment and Performance Improvement (QAPI) – Measurement and Improvement	
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:** Triple S Platino should improve its Annual QI Evaluation as follows: Make it consistent with the QI Work Plan; fully describe and enumerate results for all indicators; ensure that trending, analysis and planned corrective action is presented; present planned interventions related to goals that were not met; ensure that the member population (MA vs SNP) is clear for results presented. Triple S Platino should ensure that the QI Work	▪ 2015 Review Determination: **Substantial Compliance`**

Triple S: 2015 Medicare Managed Care Compliance Review – Follow-Up for Elements Minimal and Non-Compliant in 2013 Review (Review Year 2012-2013)	
Description of Review Findings Minimal and Non-Compliant	**Follow-Up Findings: Current Status**
Plan: addresses specific barriers identified; contains specific actions to address individual findings.	
Ensure that data received from providers are accurate and complete. **Minimal Compliance:** Triple S Platino should provide specific process and procedures used to ensure the accuracy of data provided by its vendors and providers and maintain documentation of the process and results.	▪ 2015 Review Determination: **Full Compliance**
The MCO must have a process for verifying the accuracy and timeliness of reported data. **Minimal Compliance:** Triple S Platino should provide specific process and procedures used to ensure the accuracy of data provided by its vendors and providers and maintain documentation of the process and results.	▪ 2015 Review Determination: **Full Compliance**
Guidelines consider the needs of the MCO's…enrollees. **Non-Compliance:** Triple S should develop a P/P or enhance its current P/Ps to delineate the specific process/procedure followed to approve/update guidelines including how the needs of members are considered.	▪ 2015 Review Determination: **Minimal Compliance**

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® 2014:

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)

Puerto Rico Platino HEDIS® 2014 Summary

Below are the Platino results for HEDIS® 2014. The rates highlighted in GREEN are above the NCQA Medicare mean.

Table 36: 2014 HEDIS® Measures – Platino

HEDIS® Measure	AMH 9233	MCS SNP 002	MCS SNP 009	MCS SNP 010	MMM 10974	MMM 9228	PMC 9205	Trip S 8749	Trip S 10852
Effectiveness of Care: Prevention and Screening									
Colorectal Cancer Screening (COL)	**72.99%**	**70.47%**	**72.94%**	**72.13%**	**74.16%**	**84.72%**	**80.33%**	**73.24%**	61.46%
Glaucoma Screening in Older Adults (GSO)	61.11%	**75.09%**	**79.31%**	66.94%	**71.35%**	**77.74%**	**74.46%**	68.25%	62.24%
Care for Older Adults (COA)[1]									
Advance Care Planning	21.65%	63.75%	61.68%	61.80%	81.67%	82.77%	84.31%	12.65%	13.33%
Medication Review	52.80%	87.59%	83.18%	85.16%	88.95%	89.83%	91.76%	55.96%	53.33%
Functional Status Assessment	73.72%	89.78%	84.58%	87.83%	87.06%	90.68%	91.22%	72.75%	70.91%
Pain Screening	77.13%	88.81%	83.64%	87.35%	87.33%	91.24%	90.96%	78.83%	73.33%
Effectiveness of Care: Respiratory Conditions									
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	20.98%	0.97%	0.00%	0.00%	**42.22%**	29.85%	31.47%	**40.49%**	N/A
Pharmacotherapy Management of COPD Exacerbation (PCE)									
Systemic Corticosteroid	41.39%	46.17%	44.44%	35.29%	53.49%	46.29%	44.34%	39.05%	N/A
Bronchodilator	68.32%	63.98%	38.89%	56.86%	62.79%	61.35%	60.14%	54.44%	N/A
Effectiveness of Care: Cardiovascular									
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	80.25%	**90.65%**	0.00%	**90.91%**	N/A	80.74%	82.47%	72.00%	N/A
Effectiveness of Care: Musculoskeletal									
Osteoporosis Management in Women Who Had a Fracture (OMW)	16.22%	22.56%	0.00%	20.00%	N/A	24.26%	23.60%	25.00%	N/A
Effectiveness of Care: Behavioral Health									
Antidepressant Medication Management (AMM)									
Effective Acute Phase Treatment	58.31%	51.07%	47.62%	51.69%	50.91%	50.09%	48.90%	52.77%	N/A
Effective Continuation Phase Treatment	47.96%	37.29%	38.10%	38.16%	36.28%	34.21%	33.46%	37.64%	N/A
Follow-Up After Hospitalization for Mental Illness (FUH)									
30-Day Follow-Up	**66.39%**	39.37%	27.59%	36.11%	**78.26%**	**71.00%**	**70.35%**	53.50%	N/A
7-Day Follow-Up	**40.71%**	21.43%	20.69%	15.28%	**49.57%**	**42.60%**	**46.51%**	31.85%	N/A
Effectiveness of Care: Medication Management									
Annual Monitoring for Patients on Persistent Medications (MPM)									

HEDIS® Measure	AMH 9233	MCS SNP 002	MCS SNP 009	MCS SNP 010	MMM 10974	MMM 9228	PMC 9205	Trip S 8749	Trip S 10852
ACE Inhibitors or ARBs	**93.80%**	**94.52%**	89.71%	**93.16%**	**93.04%**	**95.24%**	**93.87%**	**93.75%**	83.81%
Digoxin	**94.42%**	**95.93%**	**100.00%**	**95.24%**	**96.00%**	**96.24%**	**95.60%**	**94.47%**	N/A
Diuretics	**93.95%**	**95.36%**	89.01%	**94.53%**	**93.84%**	**95.76%**	**94.27%**	**94.49%**	83.33%
Anticonvulsants	51.91%	39.80%	22.22%	45.79%	47.83%	50.18%	45.03%	42.96%	N/A
Total	91.14%	**92.75%**	87.41%	90.82%	**91.99%**	**94.09%**	**92.07%**	**92.03%**	82.58%
Medication Reconciliation Post-Discharge (MRP)[1]	12.41%	5.11%	8.64%	6.79%	22.63%	34.31%	34.55%	11.92%	2.70%
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)									
Falls + Tricyclic Antidepressants or Antipsychotics	**66.03%**	**60.78%**	0.00%	**75.00%**	N/A	**58.56%**	**58.60%**	**51.72%**	N/A
Dementia + Tricyclic Antidepressants or Anticholinergic Agents	**84.36%**	**77.50%**	**66.67%**	**70.49%**	**77.94%**	**76.69%**	**73.07%**	**81.94%**	N/A
Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs	**29.72%**	**33.38%**	0.00%	**29.41%**	N/A	**31.60%**	**26.85%**	**32.69%**	N/A
Total	**74.90%**	**64.50%**	**57.14%**	**62.79%**	**63.89%**	**63.80%**	**60.41%**	**69.08%**	N/A
Use of High-Risk Medications in the Elderly (DAE)									
One Prescription	**46.48%**	**24.91%**	**20.10%**	**22.05%**	**27.54%**	**29.37%**	**31.82%**	**33.09%**	**33.94%**
At Least Two Prescriptions	**17.53%**	**4.68%**	**4.31%**	**4.45%**	**6.11%**	**6.09%**	**6.77%**	**8.65%**	**9.70%**
Health Plan Descriptive Information									
Board Certification (BCR)									
Family Medicine	2.30%	NR	NR	NR	NR	NR	NR	2.11%	2.11%
Internal Medicine	36.38%	NR	NR	NR	NR	NR	NR	33.38%	33.38%
OB/GYN physicians	33.64%	NR	NR	NR	NR	NR	NR	26.29%	26.29%
Pediatricians	40.00%	NR	NR	NR	NR	NR	NR	8.33%	8.33%
Geriatricians	55.26%	NR	NR	NR	NR	NR	NR	38.46%	38.46%
Other physician specialists	44.20%	NR	NR	NR	NR	NR	NR	37.00%	37.00%

[1] HEDIS® Benchmarks for the Care for Older Adults (COA) and Medication Reconciliation Post-Discharge (MRP) measures were not available in Quality Compass 2014.
NR: not reported; N/A: 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 American Health Medicare, Humana Health Plan, Medical Card System (MCS), MMM/PMC, First Plus and Triple-S for the contract year 2014. Constellation did not submit any PIPs, as this was new MCO as of 2014.

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 2014.

Methodology

IPRO prepared a summary for each of the PIPs reported by the 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 Plans of Puerto Rico Medicare Performance Improvement Project

Humana Health Plan 2014 PIP: Post-Discharge Care Coordination (PDCC) for Members Discharged from the Hospital

The following narrative summarizes the PIP conducted by Humana Health Plan (HHP) during the contract period 2014, and represents the most recent information reported to PRHIA.

The aim of the PIP is to increase member post-discharge coordination of care with the desired outcome of decreasing the hospital readmission rate.

The MCO did not state the objective of the PIP in the form of a question.

Study Population

The study population was the total plan enrollment.

Indicator

- Hospital readmission rate. The readmission rate is based on claims data using the actual plan enrollment without adjustment.

Interventions

Member Interventions

- Conduct post-discharge telephonic outreach to members discharged to home with “unable to contact letters” as needed.

Health Plan Interventions

- Improve collection of member demographic information during the enrollment process via the Market Point sales representatives.
- Validate member demographic information during any routine contacts with members.
- Improve the daily admission report by eliminating duplicate admissions and future admission dates.

- Add two additional staff members to the Post-Discharge Care Coordination team to increase member outreach.
- Planned interventions include:
  - Create a new case type in the care management system to capture post-discharge call data.
  - Use an "Auto Dialer" system to generate member outreach calls and document failed call attempts.
  - Enhance reporting to identify members for post-discharge calls.
  - Prioritize member outreach calls by assigning a Readmission Predictive Model (RPM) score to identify members with a higher risk of readmission.

Data Analysis and Results
Baseline and interim results are shown in **Table 37**.

Table 37: HHP Medicare 2014 PIP – Post-Discharge Care Coordination (PDCC)/Readmission Rate

Indicator[1]	2013 Baseline Results (MY 2012)	2014 Interim Results (MY 2013)	Change from Baseline	Difference Compared to Goal	Performance Target
Readmission Rate	12.23%	14.16%	↑1.93 Percentage points	↑2.16 Percentage points	12%

MY: measurement year; ↑ = increase; ↓ = decrease
[1] A lower rate is better performance.

Achievement of Improvement
The rate increased from 12.23% at baseline to 14.16% (+1.93 percentage points) at the interim measurement, which was 2.16 percentage points above the goal rate. Since a lower rate is better performance, the MCO did not achieve improvement.

Strengths
Key strengths include:
- The indicator is calculated using claims data and applies to the MCO's entire member population.
- The MCO clearly identified the barriers and implemented system changes.

Opportunities for Improvement
Key opportunities for improvement include:
- The MCO stated that evidence-based studies identified post-discharge care coordination as a key lever for impacting readmission rates; however, did not provide literature citations.
- The MCO should provide national and/or local statistics and literature citations to support the PIP topic selection.
- The MCO should also support the topic relevance to its membership by providing plan-specific data indicating hospital readmissions are an opportunity for improvement.
- The MCO should provide a rationale for establishing the goal rate of 12%.
- Also, the MCO should report all the indicator data, including the numerators and denominators for each measurement year.
- The MCO should clarify why the baseline readmission rates and goals reported in the interim report differ from those reported in the baseline report.
- The PIP did not achieve improvement. The interim readmission rate was 1.93 percentage points above the baseline and 2.16 percentage points above the goal rate of 12%.
- The MCO should establish process measures to assess the effectiveness of the interventions, especially in view of the lack of improvement.

Overall Credibility of Results
The validation findings generally indicate that the credibility of the PIP is generally not at risk; however, the results should be viewed with caution because the MCO did not report the denominators and numerators and the baseline

readmission rate and goal reported in the interim report differ from those reported in the baseline report without an explanation for the difference.

MCS Advantage, Inc. Medicare
Performance Improvement Project

MCS Advantage, Inc. Medicare 2014 PIP: Reducing All-Cause Hospital Readmissions

The following narrative summarizes the PIP conducted by MCS Advantage during the contract period 2014 for CMS contract #s: H5577-002, H5577-009 and H5577-010, and represents the most recent information reported to PRHIA.

The aim of the PIP is to decrease the Plan All-Cause Readmission rate (PCR).

The MCO did not state the objective of the PIP in the form of a question.

The MCO indicated two goals:

- Achieve at least a 25% decrease in the total number of members with readmissions at the end of 30 days participation in the Plan's Readmission Prevention Program.
- Achieve a 4.5 percentage point (1.5 percentage point decrease per measurement year) decrease in the 30-day all-cause plan readmission rate by the end of the 3 year project.

Indicators

- ***HEDIS® Plan All-Cause Readmission (PCR)***
- Readmission rate prior to enrolling in the Readmission Prevention Program for the Plan's Special Needs Plan (SNP) membership.
- Readmission rate after enrolling in the Readmission Prevention Program for the Plan's SNP membership.

The MCO reported the following interventions:

Member Interventions

- Care Managers conduct telephone outreach to members enrolled in the Readmission Prevention Program within 2 business days of discharge and complete a readmission prevention assessment.
- Community Outreach technician(s) will make home visit(s) for members who cannot be contacted by phone.
- Care Managers establish a care plan and begin coordination to achieve set goals.
- Care Managers contact members at least weekly to review service coordination, post-discharge visit, medication adherence and reconciliation, self-care, mental health follow-up (if needed) and social barriers that affect member access to care.
- If needed, a physician home visit will be coordinated by the care manager.

Health Plan Interventions

- Establish a Care Management Readmission Prevention Program. Members who enroll in the program are discharged by the end of the 30 days and referred to another Care Management program as needed. Members already enrolled in Care Management will participate in the Readmission Prevention Program for 30 days and then resume their prior Care Management program.

Data Analysis and Results

Baseline and interim results are shown in **Table 38** and **Table 39**.

Table 38: MCS Medicare 2014 PIP – HEDIS® Plan All-Cause Readmissions

Indicator[1]	Baseline HEDIS® 2014 (MY 2013)	Interim Q1-Q2 2014[2]	Percentage Point Change Compared to Baseline	Performance Target
Readmission rate H5577-009	9.09%	6.03%	↓3.06	↓ 1.5 percentage points/year (7.59%) ↓4.5 percentage points/3 years (4.59%)
Readmission rate H5577-010	13.50%	7.74%	↓5.76	↓ 1.5 percentage points/year (12%) ↓4.5 percentage points/3 years (9%)
Readmission rate H5577-002	12.14%	10.93%	↓1.21	↓ 1.5 percentage points/year (10.64%) ↓4.5 percentage points/3 years (7.64%)

MY: measurement year.
[1] A lower rate is better performance.
[2]Results are for the first 1st and 2nd quarters of 2014, not total year results for HEDIS® 2015 (MY 2014).

Table 39: MCS 2014 PIP – Readmission Rates Prior to and After Readmission Prevention Program

Indicator[1]	Baseline Q1-Q2[2] 2014 (Before Enrolling in Program)[3]	Interim Q1-Q2[1] 2014 (After Enrolling in Program)[4]	Percent Change from Baseline	Performance Target
Readmission rate H5577-009	43.0%	20.9%	↓51.4%	↓ 25% (32.25%)
Readmission rate H5577-010	47.4%	13.9%	↓70.7%	↓ 25% (35.55%)
Readmission rate H5577-002	21.9%	8.1%	↓63.0%	↓ 25% (16.43%)

Q: quarter; ↓ = decrease.
[1] A lower rate is better performance.
[2]Results are for Q1 and Q2 2014, not full year HEDIS® 2015 (MY 2014) results.
[3]The group "before enrolling in the program" is comprised of members who had a readmission in the 4 month period prior to enrolling in the program.
[4]The group "after enrolling in the program" reflects the percentage of members who had a readmission within the 30 day period following enrollment in the program.

Achievement of Improvement

The interim rates for Plan All-Cause Readmission for all contracts showed improvement compared to baseline. However, the rates may not be comparable because the baseline rates are for CY 2013 (12 months) and the interim rates are for Q1-Q2 2014 (6 months). The decrease in the readmission rate for members enrolled in the MCO's Readmission Prevention Program exceeded the goal of a 25% decrease in readmissions for all three contracts.

Strengths

Key strengths include:

- The MCO identified barriers causing readmissions and implemented interventions to address the barriers.
- HEDIS® data was used to calculate rates for the indicator.
- The readmission rate for members enrolled in the Readmission Prevention Program improved and exceeded the goal of a 25% decrease for all three contracts.

Opportunities for Improvement
Key opportunities for improvement include:

- The MCO should provide a rationale for selecting this topic supported with national or local statistics and data as well as citations of health services literature.
- The MCO should provide data to demonstrate the relevance of the topic to its membership.
- The MCO is addressing only a small proportion of the eligible members at risk for inpatient readmission (those who enroll in the program).
- The rates may not be comparable because the measurement periods are not consistent. The baseline measurement period is CY 2013 (12 months) and the interim measurement period is Q1-Q2 2014 (6 months). The MCO should align its measurement periods.
- The readmission rate for members enrolled in the MCO's Readmission Prevention Program exceeded the goal of a 25% decrease in the readmission rate. However, as stated above, the rates may not be comparable due to the difference in the baseline and interim measurement periods.

Overall Credibility of Results

- The validation findings indicate a bias in the PIP results. Results must be interpreted with some caution due to the study population being only a small proportion of the eligible members and inconsistent measurement periods.

First Plus Medicare, MMM Healthcare, Inc. Medicare, and PMC Medicare Choice, LLC. Performance Improvement Projects

The following narrative summarizes the PIPs conducted by First Plus/MMM/PMC during the contract period 2014, and represents the most recent information reported to PRHIA.

MMM/First Plus Medicare 2014 PIP: First-Plus Transitional Care Management/HEDIS® Plan All-Cause Readmissions (PCR)

The following narrative summarizes the PIPs reported by MMM/First Plus to PRHIA.

The aim of the PIP is to decrease the hospital readmission rate for Platino members by implementing the Transitional Care Management Program.

The MCO did not state the objective of the study in the form of a question.

Indicator
The PIP indicator was:

- HEDIS® Plan All-Cause Readmission (PCR) rate

The MCO indicated the goal was:

- Achieve at least a 25% decrease in the number of members with readmissions at the end of 30 days participation in the Plan's Readmission Prevention Program.
- Achieve a 4.5 percentage point (1.5 percentage point decrease per measurement year) decrease in the 30-day all-cause plan readmission rate by the end of the 3 year project.

The original goal was stated as a decrease the readmission rate from 14% to 12%. The goal was later changed based on the baseline rate.

Interventions
Member Interventions

- Conduct post-discharge member outreach calls to coordinate PCP appointments, complete a Needs Assessment and complete medication reconciliation.
- Continue the Admitting Physician Program (the MCO did not provide details in the PIP report).

- Reinforce PCP use of the Daily Inpatient Census available on the Provider Portal.
- Provide discharge summaries and medication reconciliation post-discharge forms to the member's PCP.
- Utilize the Transition Care Managers at Hermanos Melendez and Doctors Center Bayamon hospitals to address member admissions at these facilities.
- Provide member education and workshops regarding readmission and use of emergency rooms versus urgent care.
- Develop a communication campaign for providers regarding readmissions.

Data Analysis and Results
Baseline and interim results are shown in **Table 40**.

Table 40: MMM/First Plus Medicare 2014 PIP – Transitional Care Management/HEDIS® Plan All-Cause Readmissions (PCR)

Indicator[1]	Baseline Results CY 2012[2]	Interim Results Q1-Q3 2013[3]	Change from Baseline	Performance Target[4]
Readmission Rate	19.4%	18.5%	↓0.9 Percentage points	UTD[5]

CY: calendar year; Q: quarter; ↑ increase; ↓ decrease.
[1]A lower rate is better performance.
[2]The MCO initially reported the CY 2012 readmission rate was 14.0% and later, reported the 2012 readmission rate as 19.4%.
[3]The interim readmission rate is calculated for the period Q1-Q3 2013 (9 months), inconsistent with the baseline period (12 months).
[4]The initial goal stated in the PIP was a decrease from 14% to 12%. The goal for CY 2014 was changed from 12% to 16.0% based on the revised baseline rate of 19.4%.
[5]UTD – unable to determine, the MCO reported several different goals.

Achievement of Improvement
In the interim measurement year, the readmission rate decreased by 0.9 percentage points. The 2013 readmission rate is based on data from Q1 – Q3 2013 (9 months) compared to the baseline, CY 2012 (12 months). The 2014 readmission rate goal was restated in the PIP, increasing from 12.0% to 16.0%. The MCO achieved minimal improvement based on the decrease from 19.4% to 18.5% (- 0.9 percentage points). A lower rate is better performance.

Strengths
Key strengths include:
- The PIP identified barriers and implemented interventions to address the barriers.
- The readmission rate decreased in the interim review period. However, the measurement periods were not consistent and the baseline rate was revised without explanation.

Opportunities for Improvement
Key opportunities for improvement include:
- The MCO should state the question(s) that the PIP is intended to address.
- The MCO should support the topic selection with PIP national and local data and a literature review. The MCO should support the relevance to the plan's membership and demonstrate an opportunity for improvement by citing plan-specific data.
- The MCO should identify the specific HEDIS® measure used, the population included in the study and the criteria used to select the population and the specifications used to calculate the rate.
- The measurement periods are not consistent and therefore, the results may not be considered comparable.
- The MCO should select a specific performance target/goal with a supporting rationale.
- The MCO should provide an explanation for the revised baseline rate and the revised goal.

Overall Credibility of Results
The validation findings generally indicate that the credibility of the PIP results is not at risk. However, results must be interpreted with caution because the measurement periods are not consistent. Also, the rates were restated between the baseline and interim reports.

MMM Healthcare, LLC. Medicare 2014 PIP: Improving HEDIS Plan All-Cause Readmissions (PCR) and Care of Older Adults: Medication Review (COA-MR) Measures

The following narrative summarizes the PIP conducted by MMM during the contract period 2014 for CMS contract #s: H4003-17 and H4003-21, and represents the most recent information reported to PRHIA.

The aim of the PIP is to reduce hospital readmission rates (HEDIS® PCR) and improve compliance with the HEDIS® Medication Review measure for MMM's dual eligible members.

The MCO did not state the objective(s) of the study in the form of a question.

Indicators

- HEDIS® Plan All-Cause Readmissions (PCR).
  The goal is to reduce the readmission rates for both contracts from 12.4% to 8.8%.
- HEDIS® Care of Older Adults - Medication Review (COA-MR).
  The goal is to achieve the 90th percentile for 2015.

Interventions
The MCO implemented the following interventions to improve performance on readmission rates:

- Expanded the Admitting Physician Program in 7 regions to administer readmissions in several contracted hospitals.
- Used the Discharge Planning Unit (DPU) to proactively coordinate care post-discharge and conduct follow-up visits to assure member compliance with discharge treatment plans.
- Completed interdepartmental alignments between the Inpatient and Discharge Planning Units.
- Initiated a pilot program (2014) with two major hospitals where discharge planners are onsite to provide member education and complete the discharge process.
- Quality Health Educators at regional offices provided member education on how to avoid readmission, post-discharge medication reconciliation, medication review and the importance of follow-up at weekly workshops.
- Offered provider education regarding the Teach Back method as a tool to empower members to avoid readmissions.
- Executed mass media campaigns (newsletter, radio, television) to promote awareness of how to avoid readmissions.

The MCO implemented the following interventions to improve performance on the medication review measure:

- Continued to collect health data via the Annual Health Assessment.
- Implemented the PREVENTOUR medication review program through clinics at MMM regional offices, PCP offices and community centers.
- Implemented the Pharmacy Adherence Program (2013): collaborated with Community Pharmacies Association of PR to address adherence needs and the patient\provider\pharmacy relationship.
- Implemented the Pharmacy Advantage Program (2013-2014): a quarterly award for pharmacies to ensure that members receive the highest quality of care, information, advice and services.
- Quality Health Educators at regional offices provided member education on how to avoid readmission, post-discharge medication reconciliation, medication review and the importance of follow-up at weekly workshops.

Data Analysis and Results
Results for the Plan All-Cause Readmission (PCR) rates are shown in **Table 41**.

Table 41: MMM Medicare 2014 PIP – HEDIS® Plan All-Cause Readmission Rate (PCR)

Indicator[1]	Baseline HEDIS® 2012 (MY 2011)	Remeasurement 1 HEDIS® 2013 (MY 2012)	Change MY 2011 to MY 2012	Remeasurement 2 HEDIS® 2014 (MY2013)	Change MY 2011 to MY 2013	Goal
Readmission Rate (contract H4003-17)	12%	NR	UTD[3]	12%	0	8.8%[2]
Readmission Rate (contract H4003-21)	NR	6%	UTD[4]	9%	UTD[5]	8.8%[2]

MY: measurement year; NR: not reported; ↑ increase; ↓ decrease.
[1] A lower rate is better performance.
[2]The PIPs contain contradictory goals of 8% and 8.8%; 8.8% from "Goal Statement" is presented.
[3]UTD = unable to determine change from MY2011 to MY2012, results not provided for MY 2012.
[4]UTD = unable to determine change from MY 2011 to MY 2012, results not provided for MY 2011.
[5]UTD = unable to determine change from MY 2011 to MY 2013, results not provided for MY 2011.

Results for the Medication Review Measure are shown in **Table 42**.

Table 42: MMM Medicare 2014 PIP – HEDIS® Care of Older Adults: Medication Review (COA-MR)

Indicator	Baseline HEDIS® 2013 (MY 2012)	Remeasurement 1 HEDIS® 2014 (MY 2013)	Change from Baseline	Performance Target
Care of Older Adults: Medication Review (contract H4003-17)	53%	90%	↑37 Percentage points[1]	None provided
Care of Older Adults: Medication Review (contract H4003-21)	83%	89%	↑6 Percentage points[2]	None provided

MY: measurement year; ↑ increase ↓ decrease.
[1] For contract H4003-17, the MCO reported a HEDIS® 2014 rate of 90%, an increase of 37 percentage points from the "established benchmark (53%)".
[2] For contract H4003-21 PIP the MCO reported a HEDIS 2014 rate of 89%, an increase of 6 percentage points from the "established benchmark (83%)".

Achievement of Improvement
The readmission rate for contract H4003-17 remained unchanged at 12% between baseline (MY 2011) and remeasurement 2 (MY 2013). The MCO did not provide results for remeasurement 1 (MY 2012). The final rate (MY 2013) measure was 3.2 percentage points above the goal (8.8%).

For contract H4003-21, the MY 2011 (baseline) readmission rate was not provided. The rate did not improve from MY 2012 to MY 2013. The MY 2013 readmission rate was 9% compared to 6% in MY 2012; an increase of 3 percentage points. A lower rate is better performance. The final readmission rate (MY 2013 = 9%) was 0.2 percentage points above the goal (8.8%).

For the medication review measure, both contracts' rates improved in HEDIS® 2014 compared to baseline. The MCO reported increases of 37 percentage points and 6 percentage points.

Strengths
Key strengths include:

- The MCO identified barriers related to hospital readmissions and developed and implemented interventions to address them.
- HEDIS® data was used to calculate rates for both PIP indicators, ensuring a consistent methodology.
- The MCO reported improvement from baseline for both contracts for the HEDIS® Medication Review measure.

Opportunities for Improvement
Key opportunities for improvement include:
- For both readmissions and medication review, the MCO should support the topic selection with citations from health services literature and national and/or local statistics.
- For both readmissions and medication review, the MCO should support the topic selection with plan-specific data to support relevance to the membership and opportunity for improvement.
- The MCO should state the study question(s) that the PIP is intended to address.
- The MCO should clearly and fully report the data for all measurement periods for both indicators.
- The MCO should clearly state a goal for both indicators.
- The MCO did not achieve improvement for readmissions for either contract.

Overall Credibility of Results
For the readmission measure, the credibility of the results cannot be determined because data for one measurement period was not reported for each of the contracts H4003-17 (HEDIS 2013) and H4003-21 (HEDIS® 2012). Additionally, the goal rates were not clear.

For the medication review measure, the validation findings generally indicate that the credibility of the PIP results is not at risk. However, the goal rates were not clear.

PMC Medicare Choice, LLC. 2014 PIP: Improving HEDIS Plan All-Cause Readmissions (PCR) and Care of Older Adults: Medication Review (COA-MR) Measures

The following narrative summarizes the PIP reported by PMC Medicare Choice for the contract period 2014, and represents the most recent information reported to PRHIA.

The aim of the PIP is to reduce hospital readmission rates and improve compliance with the HEDIS® Care for Older Adults: Medication Review measure for PMC's Dual SNP eligible members.

The MCO did not state the objective(s) of the study in the form of a question.

Indicators
- HEDIS® Plan All-Cause Readmissions (PCR).
  The stated goal is to reduce the readmission rate from 13.95% to 8%.
- HEDIS® Care of Older Adults: Medication Review (COA_MR).
  The stated goal is to achieve the Quality Compass™[5] 90th percentile 2015.

Interventions
The MCO implemented the following interventions to improve performance on readmission rates:
- Expanded the Admitting Physician Program in 7 regions to administer readmissions in several contracted hospitals.
- Used the Discharge Planning Unit (DPU) to proactively coordinate care post-discharge and conduct follow-up visits to assure member compliance with discharge treatment plans.
- Completed interdepartmental alignments between the Inpatient and Discharge Planning Units.
- Initiated a pilot program (2014) with two major hospitals where discharge planners are onsite to provide member education and complete the discharge process.
- Quality Health Educators at regional offices provided member education on how to avoid readmission, post-discharge medication reconciliation, medication review and the importance of follow-up at weekly workshops.

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

- Offered provider education regarding the Teach Back method as a tool to empower members to avoid readmissions.
- Executed mass media campaigns (newsletter, radio, television) to promote awareness of how to avoid readmissions.

The MCO implemented the following interventions to improve performance on the medication review measure:

- Continued to collect health data via the Annual Health Assessment.
- Implemented the PREVENTOUR medication review program through clinics at MMM regional offices, PCP offices and community centers.
- Implemented the Pharmacy Adherence Program (2013): collaborated with Community Pharmacies Association of PR to address adherence needs and the patient\provider\pharmacy relationship.
- Implemented the Pharmacy Advantage Program (2013-2014): a quarterly award for pharmacies to ensure that members receive the highest quality of care, information, advice and services.
- Quality Health Educators at regional offices provided member education on how to avoid readmission, post-discharge medication reconciliation, medication review and the importance of follow-up at weekly workshops.

Data Analysis and Results

Baseline and interim results for the Plan All-Cause Readmission (PCR) Rates are shown in **Table 43**.

Table 43: PMC Medicare 2014 PIP – HEDIS® Plan All-Cause Readmission Rate (PCR)

Indicator[1]	Baseline HEDIS® 2012 (MY 2011)	Interim HEDIS® 2013 (MY 2012)	Change from Baseline MY 2011 to MY 2012	Final HEDIS® 2014 (MY 2013)	Change from Baseline MY 2011 To MY 2013	Goal
Readmission Rate	13%	NR	UTD[2]	13%	0	8%

MY: measurement year; NR: not reported.

[1] A lower rate is better.

[2] UTD = unable to determine change from MY 2011 to MY2012 as the results for MY 2012 were not reported.

Baseline and interim results for the Medication Review Measure are shown in **Table 44**.

Table 44: PMC Medicare 2014 PIP – HEDIS Care of Older Adults: Medication Review

Indicator	Baseline Results HEDIS® 2013 (MY 2012)	Interim Results HEDIS® 2014 (MY 2013)	Change from Baseline MY 2012 to MY 2013	Final Results HEDIS 2015 (MY 2014)	Performance Target
Care of Older Adults: Medication Review	39%	92%	↑53 Percentage points	TBD	QC 90th percentile by 2015

MY: measurement year; ↑ increase; ↓ decrease; TBD: to be determined; QC: Quality Compass.

The MCO reported a rate of 92% for HEDIS® 2014 (MY 2013), an increase of 53 percentage points from baseline (39%).

Achievement of Improvement

The rate for the readmission measure did not improve between the baseline and final measurements. The rate was 13% at both points. The final rate remained at 5 percentage points above the established goal of 8%. A lower rate represents better performance. Improvement cannot be evaluated at the interim phase; the rate was not reported.

The rate for the medication review measure increased by 53 percentage points from baseline. The stated goal was to achieve the Quality Compass™ 90th percentile in 2015.

Strengths
Key strengths include:

- The MCO identified barriers related to hospital readmissions and developed and implemented interventions to address them.
- HEDIS® data was used to calculate rates for both PIP indicators, ensuring a consistent methodology.
- The MCO reported improvement from baseline for the HEDIS® Medication Review measure.

Opportunities for Improvement
Key opportunities for improvement include:

- For both readmissions and medication review, the MCO should support the topic selection with citations from health services literature and national and/or local statistics.
- For both readmissions and medication review, the MCO should support the topic selection with plan-specific data to support relevance to the membership and opportunity for improvement.
- The MCO should state the study question(s) that the PIP is intended to address.
- The MCO should clearly and fully report the data for all measurement periods for both indicators.
- The MCO did not achieve improvement in the rate of readmissions or meet the goal of an 8% readmission rate.

Overall Credibility of Results
The validation findings generally indicate that the credibility of the PIP results is not at risk. However, the results should be reviewed with caution because the source of the benchmark for the Medication Review measure is not clearly defined in the PIP. Also, the PIP did not report readmission rate results for all measurement years.

American Health Medicare and Triple-S Medicare Performance Improvement Projects

The following narrative summarizes the PIPs conducted by American Health Medicare and Triple-S Medicare and that were in process during the contract period 2013-2014, and represents the most recent information reported to PRHIA.

American Health Medicare 2014 PIP: HEDIS® Plan All-Cause Readmissions (PCR)

The following narrative summarizes the PIP conducted by AHM in process during the contract period 2014, and represents the most recent information reported to PRHIA.

The aim of the PIP is to reduce the all-cause readmission rate for the Plan's Dual Eligible population.

The MCO did not state the objective(s) of the study in the form of a question.

Indicator

- HEDIS® Plan All-Cause Readmission (PCR) rate

  The stated goal is to reduce the readmission rate by 3 percentage points from the baseline rate.

Process Measures:

- Follow-up calls within 72 hours of discharge for 80% of members.
- Document a care plan including education on the care transition process and self management support for at least 80% of members.
- Make an educational goal call about medication reminders and PCP follow up appointments during the first week post-discharge for 100% of members.
- Establish care coordination during the first 72 hours post-discharge for 90% of members requiring care transition services.
- Complete a PCP visit within 30 days of discharge (number/percentage of members to be determined).

- Communicate with PCPs to review the member's case and provide recommendations to avoid readmission.

Interventions

- Conduct post-discharge follow-up calls to the member with at least three times within 7 business days of discharge.
- Send an educational discharge kit and a letter to the member's PCP for members who cannot be reached via telephone.
- For admissions related to congestive heart failure (CHF), Case Management will send a discharge kit with educational materials and a medication reconciliation sheet for the member to review with their PCP at their follow-up appointment.
- Implement the Bienestar educational program on healthy lifestyle, monitoring and follow-up.
- Coordinate follow-up appointments for members identified as high risk for readmission with a reminder call one day before the appointment.
- Implement automated pharmacy reminder calls for members to pick up medication refills.
- Remove prior authorization requirements for home health services, home infusion services and enteral nutritional services during the first 30 days post-discharge.
- Share discharge and readmission information with the member's PCP to promote adequate intervention and post-discharge assessment.
- Make the E-Pass application available to the PCP to monitor, document and follow-up on members' care.

Data Analysis and Results

Results for Readmission Rates are shown in **Table 45**.

Table 45: AHM Medicare 2014 PIP – HEDIS® Plan All-Cause Readmission (PCR)

Indicator[1]	Baseline HEDIS® 2012 (MY 2011)[2]	Interim HEDIS® 2013 (MY 2012)[2]	Change from Baseline MY 2011 to MY 2012	Final HEDIS® 2014 (MY 2013)[2]	Change from Baseline MY 2012 to MY 2013	Goal
Readmission Rate	15%	14%	↓1 percentage points	12%	↓3 Percentage points	↓3 Percentage points

MY: measurement year; ↑ increase; ↓ decrease.

[1] A lower rate represents better performance.

[2]The MCO reported the PIP timeframe as "beginning and end dates October 2012 to October 2014" and reported the following rates: "In 2012 our rate increased to 15%..." and "…readmission rate reported is 12%, a significant reduction… of the 14% reported on the previous year."

Achievement of Improvement

The MCO met the goal of a 3 percentage point decrease in the readmission rate compared to baseline results. The baseline rate (HEDIS 2012) was 15% and the final rate (HEDIS 2014) was 12%, a difference of -3 percentage points.

Strengths

Key strengths include:

- The topic selection was supported with national and local data and statistics.
- The MCO supported the topic selection by providing plan-specific data demonstrating the relevance of the topic the membership and the opportunity for improvement.
- The MCO achieved improvement in the readmission rate and achieved the goal of a 3 percentage point decrease. A lower rate represents better performance.

- The Plan eliminated prior authorization requirements for post-discharge home care services in an effort to improve timely delivery of post-discharge care and services.

Opportunities for Improvement
Key opportunities for improvement include:
- The MCO should provide a rationale for establishing a 3 percentage point decrease as the goal.
- The MCO identified that reaching members via telephone and/or for home visits is a barrier and that the MCO only reached 36% of members to complete a plan of care, yet the majority of interventions rely on contacting members via telephone or mail.
- The telephone and mailed outreach strategies are passive in nature.
- The MCO should consider educating members, making post-discharge follow-up plans, and confirming member contact information (i.e., phone, address, email, etc.) prior to discharge.
- The MCO identified access/lack of transportation is a barrier and should develop intervention(s) to address this.
- The MCO noted that member medication adherence is poor and should develop intervention(s) to address this.
- The MCO noted that providers do not consider follow-up appointments within 7 days to be necessary and schedule follow-up appointments beyond 7 days post-discharge. The MCO should develop intervention(s) to address this.
- The MCO should track and report the process measures to assess the interventions' progress and effectiveness.

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

Triple-S Medicare 2014 PIP: Reducing Hospital Readmissions for Congestive Heart Failure (CHF)

The following narrative summarizes the PIP conducted by Triple-S in process during the contract period 2014, and represents the most recent information reported to PRHIA.

The aim of the PIP aim is to reduce the 30-day hospital readmission rate for members with CHF.

The objective of the PIP was not stated in a question format.

Indicator
- HEDIS® Plan All-Cause Readmission (PCR) rate (specifically for members with CHF)

The goal of the PIP is to achieve a 20% reduction in the readmission rate over the course of the 3 year project.

The annual goals were a 10% reduction by October 2013 (measurement year (MY) 1) and an additional 5% reduction by October 2014 (MY 2) and October 2015 (MY 3).

Interventions
- Improve the transition of care within 7 working days of discharge by acting on the discharge plan by ensuring the member is stable, assessing the member's needs, and coordinating referrals for all services required.
- Coordinate follow-up appointments with the PCP/attending physician within 7 working days of discharge.
- Perform medication reconciliation within 7 working days of discharge and notify the member's physician of any drug interactions.
- Support the member in identifying and acting upon barriers that hinder medication compliance.

Data Analysis and Results
Baseline and interim results are shown in **Tables 46**.

Table 46: Triple-S Medicare 2014 PIP – Plan All-Cause Readmissions for Members with Congestive Heart Failure

Indicator	Baseline MY 2012 (11/1/12-10/31/13)	Interim MY 2013 (11/1/13-10/31/14)	Change from Baseline MY 2012 to MY 2013	Performance Target
CHF 30-day Readmission rate	15%	16%	↑6.7%	↓ 10% from baseline by October 2013

MY: measurement year; ↑ increase; ↓ decrease.

Achievement of Improvement

The MCO did not achieve improvement in measurement year 1 compared to baseline. At the interim measurement, the readmission rate was 16% compared to the baseline rate of 15% which represents a 6.7% increase over baseline. The PIP did not achieve the goal of a 10% reduction in the 30 day readmission rate for patients with congestive heart failure.

Strengths

Key strengths include:

- The MCO identified barriers related to readmission for members with CHF and developed and implemented interventions to address the barriers.
- The topic selection is supported by national, local data and statistics.
- The MCO supported the relevance of the topic to the membership with plan-specific data.
- The MCO used HEDIS® methodology was used to calculate the indicator, allowing for a consistent methodology.
- The MCO staff collaborated with the Social Workers in an effort to overcome the difficulties in contacting members after discharge to home.

Opportunities for Improvement

Key strengths include:

- The MCO should clearly define new\revised interventions, describing the methodology, the barriers addressed the expected outcome, and how the interventions reduce readmission rates.
- The MCO reported an increase in the readmission rate during the months of December 2012 and January, March, July and September 2013 and a 0% readmission rate during the months of February, April, May and June 2013. The MCO should confirm that the readmission rates were accurate. If the rates were accurate, the MCO should identify the factors that led to the 0% readmission rate during those months.

Overall Credibility of Results

The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to the reported readmission rate of 0% for several months during the baseline measurement period.

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. **Table 47** provides an assessment as to the degree to which the MCOs effectively addressed the improvement recommendations in the prior EQR Technical Report produced in 2014.

Table 47: Assessment of Compliance with Prior EQR Recommendations

MCO Activity	IPRO Recommendation	IPRO Assessment of Compliance
APS Medicaid: Quality		
PIPs	Ensure that performance improvement projects are methodologically sound and intervention strategies should be evidence-based and developed after conducting a barrier analysis.	Non-compliant
Compliance	Examine the regulatory requirements designated not fully met and take corrective action to achieve compliance.	Partially Compliant
HEDIS®	Evaluate 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.	Non-compliant
APS Medicaid: Timeliness		
Compliance	Examine the regulatory requirements designated not fully met, particularly those that earned minimal and non-compliance, and take corrective action to achieve compliance.	Compliant
Compliance	Ensure that acknowledgement letters are provided to members for grievances and appeal requests.	Compliant
Compliance	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.	Compliant
Compliance	Evaluate the gaps that were identified for policies and procedures related to utilization management, grievances, and appeals and revise policies and procedures accordingly.	Compliant
APS Medicaid: Access		
Compliance	Examine the identified policy and procedure gaps and update policies and procedures accordingly.	Compliant
HEDIS®	Analyze performance for the identification of IAD, conduct root-cause analysis and barrier analysis, research evidence-based improvement strategies…and implement efforts to improve access.	Non-compliant
Triple-S: Quality		
PIPs	Seek assistance and/or quality improvement training related to PIP development and intervention, particularly for study methodology, data analysis, and intervention development and implementation.	Partially Compliant
Compliance	Examine the gaps related to clinical practice guideline development policies and procedures and make necessary revisions.	Compliant
Compliance	Ensure that a QI Work Plan is developed separate from the QI Program Description and ensure ongoing updates, quarterly at a minimum.	Compliant
Compliance	Ensure that the QI Evaluation includes all relevant activities for the Medicaid LOB.	Compliant
Compliance	Establish mechanisms to assess quality of care and service provided to ISHCN.	Compliant
Compliance	Maintain and implement policies and procedures for a health information system capable of collecting, analyzing, integrating, and reporting data.	Compliant

MCO Activity	IPRO Recommendation	IPRO Assessment of Compliance
Compliance	Establish and implement policies and procedures for collecting, producing, and submitting encounter data.	Compliant
Compliance	Monitor to ensure that data received from providers is accurate and complete and prepare reports of the monitoring efforts.	Compliant
Compliance	Verify the accuracy and timeliness of reported data and complete and prepare reports of verification efforts.	Compliant
Compliance	Screen data for completeness, logic, and consistency and complete and prepare reports of the screening efforts.	Compliant
Compliance	Submit encounter data and maintain evidence of submission of data to ASES.	Compliant
HEDIS®	Continue to monitor and address HEDIS® performance measures that fall below the Medicaid mean.	Non-compliant
Triple-S: Timeliness		
Compliance	Ensure that information regarding procedures for UM authorizations and appeals is communicated to members.	Compliant
Compliance	Ensure that notice of resolution letters are in easily understood format and language and inform members of their rights to appeal and SFH and to continue benefits and how to request these rights.	Compliant
Compliance	Ensure that resolution letters contain the results of the resolution and the date.	Compliant
Compliance	Ensure that acknowledgement letters are sent and a copy (electronic or paper) is maintained in the file for all grievances and appeals.	Compliant
Compliance	Ensure that resolution letters are sent and a copy (electronic or paper) is maintained in the file for all grievances and appeals.	Compliant
HEDIS®	Consider implementing a quality initiative, perhaps a PIP, to address screening measures that fall below the HEDIS® mean.	Non-compliant
Triple-S: Access		
HEDIS®	Consider implementing a quality initiative, perhaps a PIP, to address screening measures that fall below the HEDIS® mean.	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 2013-2014, conducted in August/September 2015 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:

Table 48: Standard Compliance Designations

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-through 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 2015 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.