Puerto Rico Medicaid

Quality Management Strategy (QMS)

Revised and Updated 2022

Government of Puerto Rico

Initial Plan Vital QMS developed in 2006. Revised (5th Edition) 2022 Plan Vital QMS submitted to CMS July 2022

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Introduction

Overview

The Puerto Rico Medicaid Quality Management Strategy (QMS) provides the guidance to advance island-wide quality improvement through a focus on performance improvement by providing quality services that are patient-centered and aimed at increasing the use of preventive care and appropriate delivery of care in a timely manner. Puerto Rico Medicaid and its partners, including municipalities, health plans, hospitals, and individual care providers, are committed to improving the island's health systems by improving the care of chronic conditions, increasing screening and prevention, reducing health disparities, and addressing social risk factors that affect health. The QMS is evaluated at least annually for effectiveness via the Quality Management Evaluation and the findings of those evaluations serve to support updates to the QMS.

The QMS has been revised in accordance with the Code of Federal Regulation (CFR) at 42 CFR 438.340. This is the fifth (5th) revision of the Quality Strategy which was first developed in 2006. This document includes the elements of the QMS required by the Centers for Medicare & Medicaid Services (CMS), but also includes Puerto Rico specific quality goals and measures. The Government of Puerto Rico ("the Government" or "Puerto Rico") has delegated the managed care system to the Puerto Rico Health Insurance Administration (PRHIA) (known in Spanish with its acronym as the Administración de Seguros de Salud ("ASES") de Puerto Rico).

As with previous versions of the QMS, this 2022 update was developed to align, where possible, with other Puerto Rico healthcare and quality initiatives and with the *National Strategy for Quality Improvement in Health Care.* In an effort to demonstrate compliance with the CMS Quality Strategy requirements set forth in 42 CFR 438.340, Puerto Rico prepared a crosswalk that identifies each required element of the QMS and where it has been addressed within the QMS (Appendix A).

Program Historical Background

The Government of Puerto Rico's public policy states that the government has an inherent responsibility to furnish health care services to the Medicaid population. The public policy delineates the duties and responsibilities of the Government of Puerto Rico through its agent, ASES, to facilitate and manage the following: (1) negotiation; (2) contracting; and (3) monitoring by means of a managed care organization, which includes the quality of healthcare services. ASES maintains the authority and responsibility for the updating the QMS as required by CMS and conducting the annual evaluation of the QMS, and to ensure that the QMS is updated as needed based on

performance, feedback from stakeholders, and/or changes in policy resulting from legislative, Puerto Rico, or Federal requirements.

ASES has the responsibility to implement, administer, and negotiate through contractual arrangements those healthcare services included in the Puerto Rico Government Health Plan (GHP), which is also known as Plan Vital (both GHP and Plan Vital are used interchangeably in this document). The contracting of such services will be through those managed care organizations (MCOs) authorized by Federal and Puerto Rico law that will provide risk management as required under Titles XIX and XXI of the Social Security Act, as well under provisions in 42 CFR Part 438 and State Law 72 of September 7, 1993, as amended. As of contract year 2021, there are four managed care organizations (MCOs) within the program (Molina left the program in October 2020): First Medical Health Plan (FMHP), MMM Multi Health (MMM), Plan de Salud Menonita (PSM), and Triple S Health Plan (Triple S). ASES does not require national accreditation and currently no plans are nationally accredited for Medicaid. Behavioral Health (BH) and pharmacy benefits are MCO benefit responsibilities. The Puerto Rico is (3rd and 4th Quarter 2021) procuring a Pharmacy Benefit Manager vendor for the program. Puerto Rico does not provide Long Term Services and Supports benefits to enrollees and does not have any Federally Recognized Tribes.

Through these MCOs, the GHP provides a health insurance system that furnishes access covered services to Puerto Rico's Medicaid population- 100% of which are covered under a managed care plan as Puerto Rico has elected to offer a waiver-based section 1915(a) program. It is a mandatory managed care program which requires no waiver authority because Puerto Rico is statutorily exempt from Freedom of Choice requirements[1].

As noted at Medicaid.gov[1] the Medicaid program in Puerto Rico differs from Medicaid programs operating in each of the 50 states and the District of Columbia in three (3) important ways.

- The Puerto Rico Medicaid delivery system is a subset of the larger public government healthcare delivery system for most of the island's population. The Puerto Rico Department of Health is the single state agency, and they have a cooperative agreement with the Puerto Rico Health Insurance Administration (PRHIA) also known as Administración de Seguros Salud de Puerto Rico (ASES), which implements and administers island-wide health insurance system. Approximately half of Puerto Rico's 3.5 million residents have low incomes and depend upon the public health system for their medical care.
- Through Section 1108 of the Social Security Act (SSA), each United States territory is provided base funding to serve their Medicaid populations. For the period of July 1, 2011 through September 30, 2019, Section 2005 of the Affordable Care Act provided an additional $5.4 billion in Medicaid funding to Puerto Rico.
- Unlike the 50 states and the District of Columbia, where the federal government will match all Medicaid expenditures at the appropriate federal matching assistance percentage (FMAP) rate for that state, in Puerto Rico, the FMAP is applied until the Medicaid ceiling funds and the Affordable Care Act available funds are exhausted. The statutory FMAP local

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[1] Medicaid.gov: Puerto Rico Medicaid Overview https://www.medicaid.gov/state-overviews/puerto-rico.html

matching rate increased from 50%/ 50% to 55% federal /45% local, effective July 1, 2011. From January 1, 2014 to December 31, 2015 there is a temporary 2.2% FMAP increase for all Medicaid enrollees, bringing Puerto Rico's FMAP to 57.2%.

The environment within Puerto Rico is particularly challenging from a healthcare perspective: almost half of all Puerto Rican's are covered under Medicaid and there is widespread poverty, higher incidence of chronic illness, and a limited provider network each of which have been exacerbated by recent natural disasters. As of March 2022. 1.265 million Puerto Ricans, approximately 50% of the population[2], received their health coverage through the Government of Puerto Rico's Medicaid program, which is the highest share of Medicaid/Children's Health Insurance Program (CHIP)-funded health insurance coverage of any US state. Puerto Ricans experience higher rates of chronic conditions when compared to national averages including but not limited to hypertension (18% of Medicaid population), asthma (14.1% of Medicaid population), and diabetes (15.8% of Medicaid population). In total, 16% of the Puerto Rico Medicaid population have at least one chronic condition.

Seventy-two (72) of Puerto Rico's seventy-eight (78) municipalities are deemed "medically underserved areas",[3] with 500 doctors leaving per year (pre-Hurricane Irma and Maria in 2017). Puerto Rico has half the rate of specialists (e.g., emergency physicians, neurosurgeons) as compared to the mainland in critical fields. This is especially notable for specialist providers whom serve enrollees with chronic conditions, where needed specialists are scarce leading to severely underserved Puerto Ricans in certain areas of the Island. Given these significant challenges, ASES will continue to focus on key initiatives executed by the 2019 QMS which are discussed in section "QMS Purpose" of this document.

In 2015, the GHP implemented a new service model with objectives to transform Puerto Rico's health system that promotes an integrated approach to Physical Health (PH) and Behavioral Health (BH) and improves access to quality primary and specialty care services. The GHP Colocation and Reverse Colocation integrated models of care are designed to promote an integrated physical and behavioral health care delivery system within the program's network of providers. In the Colocation and Reverse Colocation models, the MCOs facilitate the placement of a psychologist or other type of BH Provider in each Primary Medical Group (PMG) setting. PMG's are a grouping of primary care physicians and other providers who use a coordinated care model. In the scenario of Reverse Colocation, PH services are available to Enrollees being treated in BH settings.

On November 1, 2018, ASES moved from a regional delivery system to an island-wide model with choice of MCO under the Plan Vital program. In this model, enrollees are provided choice counseling and can select an MCO that best meets their needs and desires. The island-wide approach facilitates access for all members throughout the island and allows the MCOs to establish a wide network of Providers. MCOs are responsible for ensuring continued care and provider

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[2] Medicaid and CHIP Payment and Access Commission. (2021, February). *Medicaid and CHIP in Puerto Rico*. https://www.macpac.gov/wp-content/uploads/2020/08/Medicaid-and-CHIP-in-Puerto-Rico.pdf

[3] Health Resources & Services Administration, May 2020

access for enrollees transitioning between MCOs in accordance with section 5.5 of the Plan Vital Model Contract and 42 CFR 438.62.

QMS Purpose

Per Federal requirements, States must review and update their QMS as needed, but no less than once every three (3) years (42 CFR 438.340(c) and 457.1240(e)).The 2020 QMS provides the framework to advance the GHP's focus on performance improvement (PI) activities by:

- Building a culture that is focused on outcomes,
- Efficiently deploying resources,
- Setting realistic and attainable goals, and
- Providing a pathway of progressive discipline to hold managed care contractors responsible and accountable.

Because GHP offers an integrated benefit package which includes physical health (PH) and behavioral health (BH) services, we have found each component plays a critical part in the development of the QMS.

ASES establishes the performance it wants to achieve in the program in an effort to maximize the resources without limiting access, timeliness, and quality of health care. ASES is committed to designing and implementing improvement projects focused on clinical and non-clinical program elements and improving access to services to drive prevention and promote improved health outcomes among the GHP Enrollees.

Puerto Rico-Plan Vital QMS Initiatives

As previously outlined, Puerto Rico has unique health and environmental challenges; Higher incidence of chronic conditions, access to care challenges that include both provider shortage areas and transportation challenges throughout the islands (including the Islands of Culebra and Vieques where members may need to travel to the main island for care), and widespread poverty all of which have been exacerbated by recent natural disasters. Given these ongoing challenges, the four (4) Plan Vital health improvement initiatives remain unchanged from the 2019 QMS. The 2019 – 2021 Quality Management Evaluation demonstrated progress in these key areas, but also demonstrated continued improvement opportunities.

ASES intends to continue improvement efforts towards these initiatives as they remain critical to the health of the Medicaid program and the membership. These initiatives drive the QMS Goals and Objectives covered within section 2 of this document.

1. **Healthy People Initiative:** The Healthy People Initiative focuses on preventive screening for all enrollees, including populations identified with high-cost or chronic conditions.
2. **High Cost High Need (HCHN) Conditions Initiative:** The HCHN Conditions Initiative focuses on those enrollees with a high-cost condition that may be part of the HCHN Program specified in Section 7.8.3 of the Contract. The MCOs are to propose and demonstrate cost saving initiatives, programs, and value-based payment models for provider reimbursement to address HCHN enrollees. Since November 2018, a move to risk adjustment in payment methodology provided higher premiums for those HCHC conditions.
3. **Chronic Conditions Initiative:** The Chronic Conditions Initiative focuses on those enrollees with a chronic condition. Chronic conditions are often complex, generally long-term and persistent, and can lead to a gradual deterioration of health. The MCOs shall include in the quality plan, the use of best practices for care to improve the health of those with a chronic condition.
4. **Emergency Room High Utilizers Initiative:** The Emergency Room High Utilizers Initiative is designed to identify high users of emergency services (including BH) for non-emergency situations and to allow for early interventions to ensure appropriate utilization of services and resources. The MCO will submit to ASES for approval, a work plan with detailed activities and interventions aimed at emergency room high utilizers.

To actively address these initiatives, ASES created an MCO Incentive Withhold Program: the "Health Care Improvement Program" (HCIP) that includes specific performance expectations that MCOs must achieve around these four (4) initiatives. The HCIP is a retention fund model where MCOs earn incentives based on achieving benchmark targets established by ASES for quality measures identified within each initiative category. More information can be found in Section 2 of this document and the MCO HCIP Manual which is found at Attachment 19 of the Plan Vital Model

MCO Contract. The HCIP program replaces Disease Management and other less effective elements and holds the MCOs financially responsible for meeting prescribed outcome measures.

The QMS establishes the framework for improving access, timeliness, and quality of health care through performance improvement activities, monitoring and evaluating health quality measures, such as the Health Care Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcomes Survey (HOS), MCO required operational and quality reporting, EPSDT and starting in 2022, CMS Adult and Child Core Measure Sets. In addition to oversight and monitoring of quality and performance reporting, ASES conducts MCO oversight to ensure compliance with Plan Vital Model MCO Contract standards including care management program requirements. The contract requires MCOs to operate an enhanced Care Management (CM) Program that has been designed to:

- Promote wellness for healthy populations to remain healthy and avoid progression to chronic conditions
- Improve the health outcomes of the Medicaid population and devote greater resources and interventions to the medically complex by identifying high-cost/high-need (HCHN) populations
- Increase coordination between the enrollee's health care needs and all treating providers
- Ensure enrollees with special health care needs, those with high-cost, high-needs (as defined by the HCHN program), those with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) and enrollees who have accessed the emergency department seven or more times in the last 12 months are populations of focus for the MCO care management programs

Program Membership

Puerto Rico has sole authority to determine eligibility for GHP, as provided in Federal law and Puerto Rico's State Plan, with respect to the Medicaid and CHIP eligibility groups. The island has a diverse geography covering 78 municipalities, which includes a mix of urban/semi-urban, suburban and rural areas. Figure #1 below outlines the municipalities throughout the island:

Figure #1: Service One Region
Puerto Rico Health Insurance (PRHI)

Like many Medicaid programs, Puerto Rico has seen an increase in Medicaid/CHIP enrollment during the CY2019-CY2021 timeframe with enrollment of around 1.2 million members for CY2021. Puerto Rico Medicaid serves a significant percentage of the Island's population with roughly 43.5% of Puerto Ricans receiving their health coverage from Medicaid/CHIP, which is the highest share of Medicaid/CHIP-funded health insurance coverage of any U.S. state. In total, 16% of the Puerto Rico Medicaid population have at least one chronic condition.

Figure 2: Plan Vital Monthly Medicaid/CHIP Enrollment CY2019-CY2021
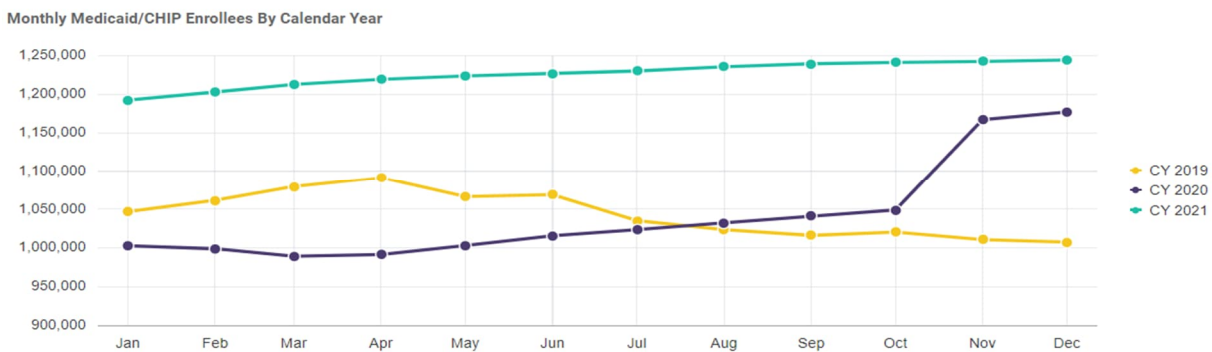
The total population insured under GHP is 1,190,324 Medicaid, 92,938 CHIP and 18,022 Commonwealth population. The "Commonwealth Population," is comprised of individuals, regardless of age, who meet State eligibility standards established by the Puerto Rico Medicaid Program but do not qualify for Medicaid or CHIP. The following charts illustrate the insured population by eligible category, gender and age:

Figure 3: Membership by population Type

GHP Membership 2021 by Population Type
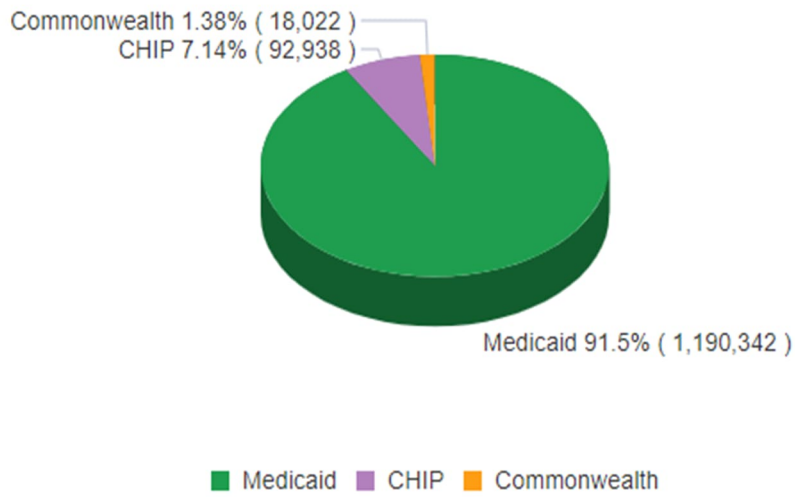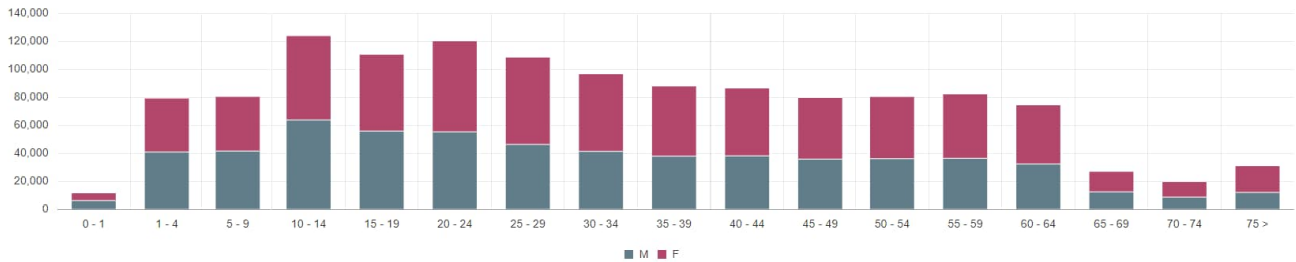
Commonwealth 1.38% (18,022)
CHIP 7.14% (92,938)

Medicaid 91.5% (1,190,342)

■ Medicaid　■ CHIP　■ Commonwealth

Figure 4: Membership by Age and Gender (CY2021)

Membership 2021 by gender (M/F) and age breakouts

■ M　■ F

Additionally, the population experiences higher rates of chronic disease than many States:

Figure 5: Prevalence Rates for Chronic Conditions CY 2021

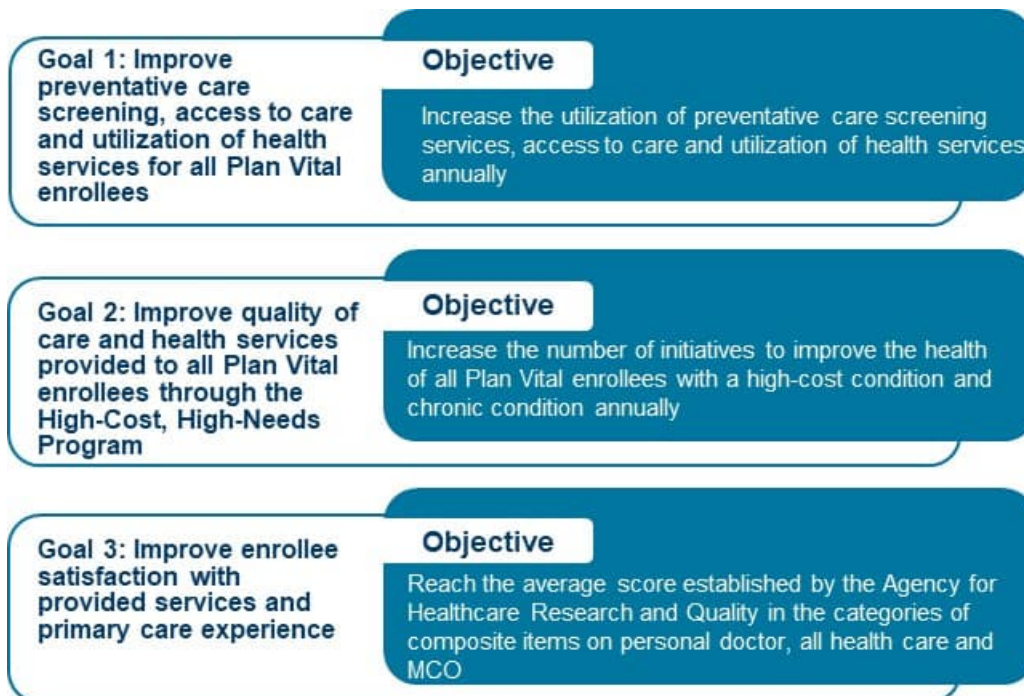| Population	Condition		Count of Members	Prevalence Percentage
CHIP	Chronic Conditions	ADHD	4,493	4.84%
CHIP	Chronic Conditions	Asthma	8,270	8.90%
Medicaid	Chronic Conditions	Asthma	86,995	7.31%
Medicaid	Chronic Conditions	COPD	17,066	1.43%
Medicaid	Chronic Conditions	Chronic Depression	41,209	3.46%
CHIP	Chronic Conditions	Diabetes	3,587	3.86%
Medicaid	Chronic Conditions	Diabetes	209,288	17.58%
Medicaid	Chronic Conditions	Hypertension	236,498	19.87%
Medicaid	Chronic Conditions	SMI	9,307	0.78%
Medicaid	Chronic Conditions	Severe Heart Failure	16,478	1.38%
CHIP	High-Cost Conditions	Autism	1,347	1.45%
CHIP	High-Cost Conditions	CYSHCN	4,594	4.95%
Medicaid	High-Cost Conditions	Cancer	26,942	2.26%
CHIP	High-Cost Conditions	Cancer	268	0.29%
Medicaid	High-Cost Conditions	ESRD	13,160	1.11%
CHIP	High-Cost Conditions	Hemophilia	10	0.01%
Medicaid	High-Cost Conditions	Multiple Sclerosis	1,708	0.14%
Medicaid	High-Cost Conditions	Rheumatoid Arthritis	13,505	1.13%

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Quality Program

Quality Strategy Goals and Objectives

As noted, the four (4) Plan Vital health improvement initiatives remain unchanged from the 2019 QMS as the 2019 Quality Management Evaluation demonstrated progress in these key areas, but also continued improvement opportunities and these initiatives remain critical to the health of the Medicaid program and the membership. Building off these initiatives, ASES has developed specific goals and objectives for the program, which are based on Puerto Rico's desire to provide patient-centered quality services aimed at increasing the use of screening, prevention, and appropriate delivery of care in a timely manner to all Medicaid, CHIP and Medicare/Medicaid Dual Eligible enrollees.

The QMS provides the framework to communicate Puerto Rico's vision of performance-driven goals and objectives and monitoring strategies that address quality of care and timely access to services. It is a comprehensive approach that drives quality through assessment, performance improvement projects (PIPs), program oversight and monitoring and outcome-based MCO evaluations.

The specific goals and objectives that play a significant role in the development of Puerto Rico's Quality Management Strategy are:

Goal 1: Improve preventative care screening, access to care and utilization of health services for all Plan Vital enrollees	**Objective** Increase the utilization of preventative care screening services, access to care and utilization of health services annually
Goal 2: Improve quality of care and health services provided to all Plan Vital enrollees through the High-Cost, High-Needs Program	**Objective** Increase the number of initiatives to improve the health of all Plan Vital enrollees with a high-cost condition and chronic condition annually
Goal 3: Improve enrollee satisfaction with provided services and primary care experience	**Objective** Reach the average score established by the Agency for Healthcare Research and Quality in the categories of composite items on personal doctor, all health care and MCO

ASES recognizes that effective quality improvement must be methodical, ongoing and measurable. For the QMS, a mix of quantitative and qualitative measures have been identified to monitor clinical quality, access and utilization management (UM) for the program. Puerto Rico prefers to use nationally recognized measure sets whenever possible, including the National Committee for Quality Assurance (NCQA) HEDIS and the Medicaid Adult and Child Core Measurement Sets. Several tools have been developed to facilitate the implementation of the QMS.

Health Care Improvement Program (HCIP)

The HCIP is one of the tools developed by ASES to reach this goal. The HCIP Program is a financial withhold with incentives for MCOs to improve the quality of the program. ASES created quality measures for each HCIP Initiative Area with a methodology tied to improving those quality measures. MCOs are required to track and report on each of the four () HCIP Initiative Areas and report all HCIP quality measures quarterly. The table below provides a high-level summary of the HCIP quality measures. A detailed list can be found in Appendix A of this document.

HCIP Initiative Area	Description	Quality Measures
High Cost- High Need (HCHN) Conditions Cancer, End-Stage Renal Disease, Multiple Sclerosis, Children and Youth with Special Healthcare Needs, and Autism	The High Cost Conditions Initiative focuses on those enrollees with a high-cost condition that may be part of the HCHN Program specified in Section 7.8.3 of the Contract. The MCOs are to propose and demonstrate cost saving initiatives, programs, and value-based payment models for provider reimbursement to address HCHN enrollees.	▪ 5 Quality Measures- Mix of Adult and Child and mix of Medical and Behavioral Health
Chronic Conditions Diabetes, Asthma, Severe Heart Failure, Hypertension, COPD, Chronic Depression	The Chronic Conditions Initiative focuses on those enrollees with a chronic condition. Chronic conditions are often complex, generally long-term and persistent, and can lead to a gradual deterioration of health. The MCOs shall include in the quality plan, the use of best practices for care to improve the health of those with a chronic condition.	▪ 6 Quality Measures- Mix of Adult and Child and mix of Medical and Behavioral Health
Healthy People	The Healthy People Initiative focuses on preventive screening for all enrollees, including populations identified with high-cost or chronic conditions	▪ 10 Quality Measures- Mix of Adult and Child and mix of Medical and Behavioral Health
Emergency Room High Utilizers	The Emergency Room High Utilizers Initiative is designed to identify high users of emergency services (including BH) for non-emergency conditions	▪ 1 Quality measure focused on ED utilization for high-utilizers of ED services

In addition to the financial incentives built into the HCIP Program, MCOs must develop and demonstrate initiatives to improve the health of the population for each scored measure within the HCIP.

HEDIS, CAHPS and ECHO Reporting

To facilitate ASES' oversight of both the MCOs and the overall Plan Vital program, MCOs are required to submit audited Annual HEDIS measure reporting, enrollee and provider satisfaction

survey data and analysis at least annually using CAHPS and the Experience of Care and Health Outcomes (ECHO) survey instruments.

Meeting Goals and Objectives

ASES's focus is to provide quality services that are patient-centered, promote integration of PH and BH services, and increase the use of screening, prevention and appropriate delivery of care in a timely manner to all Medicaid, CHIP and Medicare/Medicaid Dual Eligible enrollees. ASES has contracted with MCOs to partner and deliver on the quality goals and objectives. The goals and objectives address, and are sensitive to, the special needs populations as well as those that qualify for HCHNs and outline the requirements in terms of services, deliverables, performance measures and health outcomes within the contract. Regular and consistent review of the QMS will highlight progress toward goals and measures and related MCO progress. The outcome findings will demonstrate areas of compliance and non-compliance with Federal standards and contract requirements. This systematic review will advance trending year-over-year to engage contractors in continuous monitoring and improvement activities that ultimately impact the quality of services and reinforce positive change.

The strategies and interventions addressed in this QMS are focused on the health promotion, prevention and improving the quality of life, care and services as referenced in Attachment 19 of the contract. The specific quality and scored measures required for each initiative are defined in detail within the HCIP Manual. The MCOs must develop initiatives to improve the health of the population for each health condition identified through the indicators listed in the manual.

Additional strategies developed by ASES to achieve goals and objectives, and established in the quality strategies are:

- Developing and maintaining collaborative agreements among public agency stakeholders to improve health education and health outcomes as well as manage vulnerable and at-risk enrollees.
- Improve health information technology (HIT) to ensure that information retrieval and reporting are timely, accurate and complete.
- Improving the health of enrollees through the identification of social determinants of health and health disparities.
- A method of monitoring, analyzing, evaluating and improving the delivery, quality and appropriateness of health care furnished to all enrollees (including over, under and inappropriate utilization of services) and including those with special health care needs.

Population Health

ASES, through a data-driven approach, analyzes claims/encounter data and the External Quality Review (EQR) report on an annual basis with the purpose to identify and incorporate quality improvement strategies on conditions prevalent in the GHP Enrollees. The membership data that is stratified is used to identify specific social aspects that are critical to developing appropriate interventions. Age, race, ethnicity, gender, and preferred language are examples of the

demographic data included when stratifying enrollees. The data analysis process provides the opportunity to study strategies and interventions for the prevention of the most prevalent conditions.

Reviewing membership for CY2021, 49.34% of enrollees meet the definition as high-cost or chronic conditions accounting for 48.1% of the total health cost. The conditions identified within high-cost conditions include cancer, end stage renal disease, rheumatoid arthritis, diabetes, asthma, hypertension and chronic obstructive pulmonary disease as the chronic conditions. The current program allows for greater resources, efforts and interventions be devoted to the need and to implement integrated care programs for people with high-cost conditions, high-need and socioeconomic factors based on morbidity, use of services and HCHN.

Members 2021 with Key Conditions
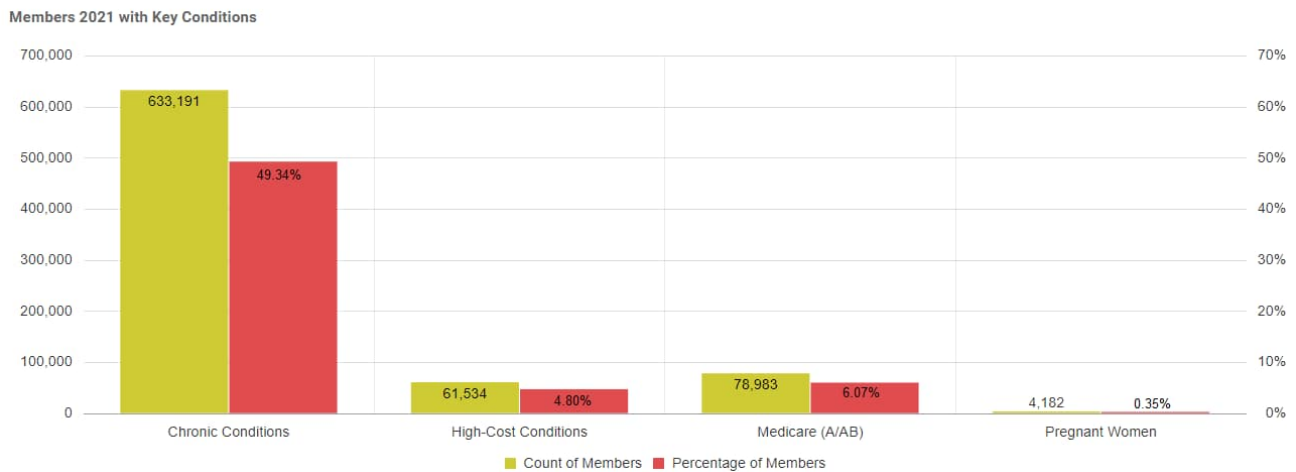
Population Type	Condition		Count of Members*
CHIP	Chronic Conditions	ADHD	4,493
CHIP	Chronic Conditions	Asthma	8,270
Medicaid	Chronic Conditions	Asthma	86,995
Medicaid	Chronic Conditions	COPD	17,066
Medicaid	Chronic Conditions	Chronic Depression	41,209
CHIP	Chronic Conditions	Diabetes	3,587
Medicaid	Chronic Conditions	Diabetes	209,288
Medicaid	Chronic Conditions	Hypertension	236,498
Medicaid	Chronic Conditions	SMI	9,307
Medicaid	Chronic Conditions	Severe Heart Failure	16,478
CHIP	High-Cost Conditions	Autism	1,347
CHIP	High-Cost Conditions	CYSHCN	4,594
Medicaid	High-Cost Conditions	Cancer	26,942
CHIP	High-Cost Conditions	Cancer	268
Medicaid	High-Cost Conditions	ESRD	13,160
CHIP	High-Cost Conditions	Hemophilia	10
Medicaid	High-Cost Conditions	Multiple Sclerosis	1,708

Medicaid	High-Cost Conditions	Rheumatoid Arthritis	13,505
Medicaid, CHIP and Commonwealth	Medicare (A/AB)	Dual Medicare (A/AB)	78,983
Medicaid and Commonwealth	Pregnant Women	Pregnant Women	4,182

*Numbers are not unique counts- members may have more than one condition within the table.

Special Health Care Needs

Special health care needs are defined as any physical, developmental, mental, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs. In accordance with Federal Regulation 42 CFR 438.340(b)(9), ASES has established a Special Coverage benefit designed to provide services for enrollees with special health care needs caused by serious illness. The requirements of the Special Coverage benefit are in section 7.7 and Attachment 7 of the contract.

MCOs monitor and routinely update a treatment plan for each enrollee who is registered for Special Coverage. The treatment plan shall be developed by the Enrollee's Primary Care Provider (PCP), with the enrollee's participation, and in consultation with any specialists caring for the enrollee. MCOs require, in its Provider Contracts with PCPs, that Special Coverage treatment plans be submitted to the MCO for review and approval in a timely manner. A list of conditions considered in Special Coverage is outlined in the Plan Vital MCO Reporting Guide which also provides specific guidance on the identification of members with special healthcare needs.

High-Cost/High-Needs Enrollees (HCHN)

HCHN enrollees are identified as enrollees with a specific set of conditions that require additional management due to the cost or elevated needs associated with the condition as defined within Attachment 25 and 7.8.3 of the contract. HCHN enrollees are to be offered Care Management (CM) with the objective to emphasize prevention, continuity of care and coordination of care, including between settings of care and appropriate discharge planning for short- and long-term hospital and institutional stays. CM will advocate for, and link enrollees to, services as necessary across providers, including community and social support providers, and settings. The specific performance measures associated with the HCHN program are detailed within the HCIP Manual, Attachment 19 of the Contract.

High-Utilizer Program

The High-Utilizer Program is designed to identify and intervene for enrollees identified with patterns of high utilization as described in Attachment 25. Reporting metrics are described within Attachment 16 of the Contract.

Quality Management Strategy Feedback Process

The QMS is designed to ensure that services provided to enrollees meet or exceed established standards for access to care, clinical quality of care and quality of service. In accordance with 42 CFR 438.340(c)(2), the QMS will be reviewed and updated no less than once every three (3) years.

ASES will achieve this ongoing review and evaluation through reporting, oversight and monitoring of the MCOs and through its External Quality Review Organization (EQRO). The Puerto Rico Medicaid program is in the process of reprocuring the EQR vendor. ASES will submit a revised QMS at any point if there is a significant change as a result of the ongoing review and evaluation. A significant change will encompass major program changes (i.e., new/change in services, new/change in populations) or a change in any of the program goals. The public input process described in further detail below will be utilized for any resubmission of the QMS to CMS.

In accordance with 42 CFR 438.340(c)(1), GHP enrollees, the general public, and stakeholders have been provided the opportunity to provide input and recommendations regarding the content and direction of the QMS. The QMS was posted on the ASES website for a 60-day period from April 2022-May 2022 with public notices requesting public feedback via multiple methods including mail, email and telephonic[4]. The final QMS, approved by CMS, will be posted to the ASES website once any edits or changes are incorporated from the feedback received at this link: https://www.asespr.org/beneficiarios/sobre-ases/medicaid-quality-strategy-cms/

ASES will continue to seek participant and family/guardian, stakeholder, and public input into the review and evaluation of the QMS on an ongoing basis. This is achieved through the Advisory Board delegated to the MCOs in accordance with Section 12.1.8 of the Contract, as well as enrollee and provider satisfaction surveys, enrollee grievances and appeals, and public forums for the GHP program. ASES will incorporate recommendations from enrollees, the general public, MCOs, the EQRO and other stakeholders in setting new goals and revising the QMS as an ongoing process.

ASES has contractual requirements in place for ensuring MCOs' compliance with the structure and operational standards of 42 CFR 438, Subpart D. ASES evaluates the effectiveness of the QMS through ongoing monitoring efforts and oversight of the MCOs. CMS requires the QMS be reviewed and updated no less than once every three years per 42 CFR 438.340(c)(2). ASES will submit a revised QMS at any point there is a significant change as a result of ongoing review and evaluation. A significant change will encompass major program changes (i.e., new services, new populations) or a change in any of the program goals. Public input is important to the process; participant feedback will be obtained through the MCO Advisory Committee, as well as member and provider satisfaction surveys and member grievances and appeals. This final draft of the QMS, as well as the evaluation of the effectiveness of the previous QMS was posted for a 60-day period to receive public input for incorporation into the QMS.

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[4] Puerto Rico Medicaid, Quality Management Strategy-Final Draft for Public Comment. Updated 2022. https://www.asespr.org/wp-content/uploads/2022/03/PR-Medicaid-QMS_2022-Update_FINAL-DRAFT-FOR-PUBLIC-COMMENT.pdf

3

Standards, Guidelines and Definitions

Quality and Appropriateness of Care

ASES monitors how well the MCOs are complying with contractual standards consistent with 42 CFR 438.340(c)(i) through the following mechanisms:

- Quality Assurance and Performance Improvement (QAPI) Program
- Puerto Rico-specific data collection and monitoring, and MCO reporting
- External Quality Review Organization (EQRO) reports
- CMS 416 report
- Health Care Improvement Program (HCIP)

All GHP contracts include quality provisions as well as requirements for quality measurement, quality improvement and reporting. ASES receives monthly, quarterly and annual report submissions from the MCOs and evaluates whether the MCO has satisfactorily met contract requirements. Another major source of information through which ASES assess quality of care is through the requirement of a QAPI. The QAPI Program is aimed to increase the health outcomes of GHP enrollees through the provision of health services that are consistent and compliant with national guidelines, and NCQA HEDIS standards. The MCOs QAPI Program is submitted to the ASES for review and approval.

The required list of reporting measures is included in Attachment 16 of the Contract, the Plan Vital Reporting Guide and Attachment 19 of the contract (HCIP Manual). At least annually, ASES will identify and publish selected performance measures.

Cultural Competency

The Puerto Rico Medicaid Program obtains race, ethnicity, and primary language from the enrollment form completed by the recipient and provides this information to its MCOs at the time of enrollment. In addition, ASES requires that all MCOs have a Cultural Competency Plan in place. This plan must describe how the providers, individuals and systems within the MCO will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth and dignity of enrollees. MCOs will serve enrollees in accordance with 42 CFR 438.340(b)(6) and will not discriminate against, or use any policy or practice that has the effect of discriminating against, an individual on the basis of (i) health status or need for services or (ii) race, color, national origin, ancestry, spousal affiliation, sexual orientation and/or gender identity. As part of the evolution of MCO reporting, ASES is adding the CMS Adult and Child Core Sets as required reporting for MCOs starting in July 2022 (4th) year of

contract with the MCOs. ASES will also incorporate evaluation of health disparity information for those HEDIS measures with new health disparity reporting requirements to support the evaluation of health disparities within the population.

ASES Selected HEDIS Measures

As a component of ASES' quality assessment process and in compliance with 42 CFR 438.340(b)(3)(i), ASES requires that all MCOs report on a specific set of HEDIS measures as selected and communicated by ASES for each calendar year. ASES collects and reviews HEDIS measure reporting from the MCOs as well as a selection of CMS Adult and Child Core Measure Sets. Starting in July 2022, MCOs will be required to report the full CMS Adult and Child Core Sets. To support Adult and Child Core Measure reporting, MCOs will be provided technical assistance training.

Clinical Practice Guidelines

The MCOs shall adopt clinical practice guidelines (CPGs) in accordance with the criteria in 42 CFR 438.236 and 10.2.2.9 of the contract. CPGs shall provide evidenced-based care guidance for clinical decision making, enrollee education and coverage of service determinations, and allow for consistency and inter-rater reliability. CPGs shall be disseminated to all affected providers, and upon request, to enrollees and potential enrollees.

Member Satisfaction

Quality Surveys are required for assessing and monitoring the quality, appropriateness of care and services furnished to GHP enrollees. MCOs are required to perform a CAHPS satisfaction survey for PH and an ECHO survey for BH, in accordance with Section 12.7.1 of the contract. Both surveys cover topics that are important to enrollees and focus on aspects of quality that enrollees are best qualified to assess, such as the communication skills of providers and ease of access to health care services. MCOs shall have a process for notifying providers and enrollees about the availability of survey findings and making survey findings available upon request. MCOs are required to use the results of the CAHPS and ECHO surveys for monitoring service delivery and quality of services, and for making program enhancements.

Monitoring and Compliance

As part of the monitoring and in conformance with 42 CFR 438.206, 438.207, 438.208, 438.210, all MCOs submit utilization statistical reports to ASES. ASES requires all reports as outlined within Attachment 16 and the Plan Vital Reporting Guide, with data to be submitted according to specifications determined in Article 18 of the Contract and following the reporting requirements as described in detail through the reporting guide provided.

An important enhancement to the Puerto Rico Medicaid program includes the development of the *Comprehensive Oversight and Monitoring Program (COMP)* which is a centralized platform that aggregates Medicaid program data, reporting from claims, MCO required reporting, Adult and Child Core Measure Sets, and *Early and Periodic Screening, Diagnostic and Treatment (EPSDT)* reporting to provide the ASES team with an array of program oversight and program integrity

information within one location. The COMP tool allows ASES to monitor and conduct compliance oversight of their MCOs activities including contractual obligations, federal requirements, overall financial health, key performance indicators (KPIs), and related comparison benchmarks to monitor MCO performance in several areas: clinical quality, finance, program integrity, network adequacy, claims and encounter operations, and pharmacy operations. Future iterations of the COMP will include centralized CMS Adult and Child Core set reporting. The COMP platform includes key performance metrics with benchmarks, a centralized location for routine reporting and other program data collection that can be visualized in interactive dashboards, includes information on MCO operational reviews, and allows ASES to establish and monitor corrective actions when required.

The COMP was intentionally designed to address the following "Key Elements of an Oversight and Monitoring Program" designed specifically to streamline and build efficiencies for State Medicaid Managed Care Program's oversight and monitoring responsibilities.

Graphic 1: Key Elements of an Oversight and Monitoring Program
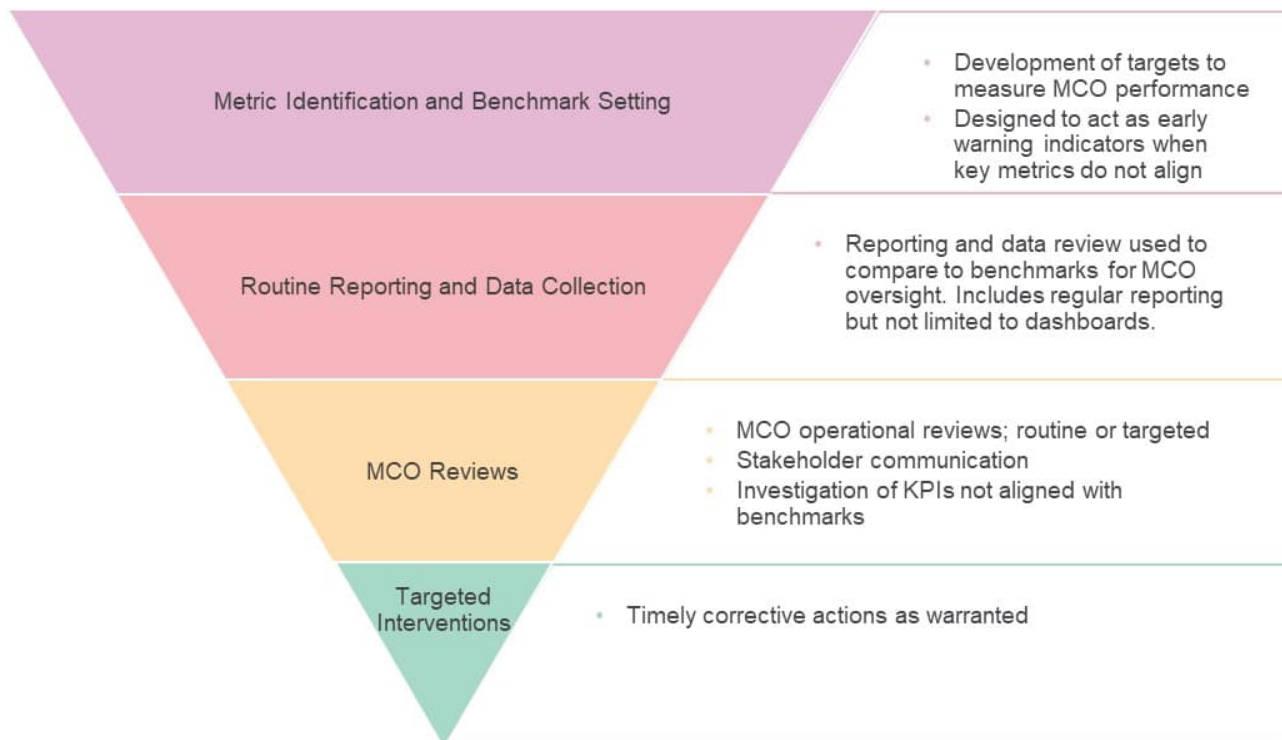
External Quality Review

To ensure the accuracy and validity of the data submitted and in compliance with 42 CFR 438.350 and 438.358, ASES contracts with an EQRO to conduct annual, independent reviews of the QMS. This includes the review of quality outcomes, timeliness of, and access to, the services covered under the GHP and validation of performance measures and PIP projects. To facilitate this process, the MCOs supply data, including but not limited to claims data and medical records, to the EQRO. In

2022, the Puerto Rico Medicaid Agency is in the process of reprocuring the EQR vendor for the program. The EQRO's Scope of Work includes all CMS mandated EQRO protocols and includes the following:

1. **Performance Improvement Projects (PIPs)** as required under 42 CFR 438.340(b)(3)(ii). The MCOs shall conduct PIPs in accordance with ASES and, as applicable, Federal protocols. The PIPs will be developed, implemented and maintained following the protocols outlined in Section 12.3 of the contract. At a minimum, the topics of the PIPs are:

   A. One clinical care project in the area of increasing fistula use for Enrollees at-risk for dialysis;

   B. One clinical care project in the area of BH;

   C. One administrative project in the area of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening;

   D. One administrative project in the area of reverse co-location and co-location of PH and BH and their integration; and

   E. The Contractor shall conduct additional PIPs as specified by ASES during the Contract Term.

2. **Program Integrity** (PI) The evaluation in this area includes at a minimum the review of MCOs' policies and procedures, training programs, reporting and analysis; compliance with Annual Disclosure of Ownership (ADO) and financial interest provisions; and file review of program integrity cases.

In compliance with 42 CFR 438.364, the EQRO submits an EQR Technical Report to ASES that includes the following information for each mandatory activity conducted:

• Activity objectives
• Technical methods of data collection and analysis
• Description of data obtained
• Conclusions drawn from the data

The report also includes an assessment of the MCOs' strengths and weaknesses, as well as recommendations for improvements. ASES uses the information obtained from each of the Mandatory EQR activities, as well as the information presented in the EQR technical report, to make programmatic changes and modifications to the QMS. ASES monitors MCO performance against certain standards to potentially identify opportunities to use other survey results for evaluation in an effort to minimize duplication of activities. ASES does not utilize the non-duplication option with their EQRO.

In August of 2021, ASES conducted an assessment of the Plan Vital contracted managed care organizations (MCOs) program integrity (PI) compliance. The objective of the review was to evaluate each MCO's processes for the prevention, detection, and recoupment of improper payments to ensure compliance with regulatory and contractual responsibilities. The analysis covered four (4) MCOs contracted with the Vital program: First Medical Health Plan (FMHP), MMM

Multi Health, LLC (MMM), Plan De Salud Menonita (PSM), and Triple-S Salud (SSS). The evaluation analyzed MCO operations for the following nine (9) PI standards:

- Standard 1 Written Policies and Procedures

- Standard 2 Corporate Staffing

- Standard 3 Training

- Standard 4 Communication

- Standard 5 Disciplinary Guidelines

- Standard 6 Internal and External Monitoring

- Standard 7 Response to Offenses

- Standard 8 Member Verification

- Standard 9 Payment Suspension and Excluded Providers

Results of the Program Integrity review are being utilized to identify program improvement opportunities and determine corrective actions required for each MCO.

Puerto Rico Standards

Provider Network Access Standards

Contract provisions in Article 9 of the contract are established to incorporate specific standards on the MCOs for the elements in accordance with 42 CFR 438.68, 438.206, 438.207, and 438.214 MCOs are responsible for communicating established standards to network providers, monitoring provider compliance and enforcing corrective actions as needed. ASES conducts readiness reviews of the MCOs' operations related to the contract that includes, at a minimum, one onsite review and desk reviews of policies and network development to receive assurances that the MCOs are able and prepared to provide all required services. The EQR conducts a validation of the network standards at a minimum, once every three (3) years as outlined in 42 CFR 438.358(b)(1)(iv). The network adequacy standards are provided within Attachment 20 of the Contract. The following table provides the contract provision in each of the mentioned categories:

Federal Regulation	Description	GHP Contract Reference
438.206	Availability of services	9.1.2
438.206(b)(1)	Maintains and monitors a network of appropriate Providers	9.3
438.206(b)(2)	Female Enrollees have direct access to a women's health specialist	9.3.1.10
438.206(b)(3)	Provides a second opinion from a qualified health care professional	11.7
438.206(b)(4)	Adequately and timely coverage of services not available in-network	9.3.1.8

Federal Regulation	Description	GHP Contract Reference
438.206(b)(5)	Out-of-network Providers coordinate with the MCO with respect to payment	9.3.1.8
438.206(b)(6)	Credential all Providers as required by 42 CFR 438.214	9.2.3
438.206(c)(1)(i)	Providers meet state standards for timely access to care and services	9.1.5.3, 11.4.2
438.206(c)(1)(ii)	Network Providers offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or comparable to Medicaid fee-for-service	9.5.3.1
438.206(c)(1)(iii)	Services included in the contract are available 24 hours a day, 7 days a week	10.3.1.3.34
438.206(c)(1)	Mechanisms/monitoring to ensure compliance by Providers	9.3.3.5.1.2
438.206(c)(2)	Culturally competent services to all Enrollees	6.11
438.207	Assurances of adequate capacity and services	9.1.13
438.207(a)	Assurances and documentation of capacity to serve expected enrollment	9.1.13.2
438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services	9.1.13.1.2
438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution	9.1.3.7
438.208	Coordination and continuity of care	7.8.2.3, 9.3.3, 9.3.1.5.1
438.208(b)(1)	Each Enrollee has an ongoing source of primary care appropriate to his or her needs	9.3.1.5
438.208(b)(2)	All services that the Enrollee receives are coordinated with the services the Enrollee receives from any other MCO/PIHP	5.5 (all services are under one MCO)
438.208(b)(3)	Share with other MCOs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services	9.5.2
438.208(b)(4)	Protect enrollee privacy when coordinating care	5.3.8.3
438.208(c)(1)	State mechanisms to identify persons with special health care needs	9.5.2
438.208(c)(2)	Mechanisms to assess enrollees with special health care needs by appropriate health care professionals	9.5.2
438.208(c)(3)	If applicable, treatment plans are developed by the enrollee's PCP with Enrollee participation, and in consultation with any specialists caring for the Enrollee; approved in a timely manner; and in accord with applicable state standards	9.5.2
438.208(c)(4)	Direct access to specialists for enrollees with special health care needs	9.5.2.2
438.210	Coverage and authorization of services	11.2.4.2, 11.4

Federal Regulation	Description	GHP Contract Reference
438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service	9.1.2
438.210(a)(2)	Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid	9.1.2
438.210(a)(3)(i)	Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished	9.1.2
438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	7.1.2
438.210(a)(3)(iii)	Each MCO may place appropriate limits on a service, such as medical necessity	7.2
438.210(a)(4)	Specify what constitutes "medically necessary services"	7.2
438.210(b)(1)	Each MCO and its subcontractors must have written policies and procedures for authorization of services	11.2.1
438.210(b)(2)	Each MCO must have mechanisms to ensure consistent application of review criteria for authorization decisions	11.2.1.1
438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate health care professional	11.2.1.9
438.210(c)	Each MCO must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested	14.4.1
438.210(d)	Provide for the authorization decisions and notices as set forth in 42 CFR 438.210(d)	11.2
438.210(e)	Compensation to individuals or entities that conduct UM activities does not provide incentives to deny, limit, or discontinue medically necessary services	11.2.4

Measurement and Improvement Standards

The GHP contract requires an ongoing program for quality assessment and Program Integrity (PI) of the services provided to enrollees as required in 42 CFR 438.236 and 42 CFR 438.242. Quality measurement and improvement standards include CPGs, preventive services, PH and BH integration and health information systems (IS). Each of these standards is defined as follows:

1. **Clinical Practice Guidelines:** ASES requires that MCOs adopt clinical standards consistent with current standards of care that are evidence based, complying with recommendations of professional specialty groups or the guidelines of programs such as: Puerto Rico Department of Health, American Academy of Pediatrics, American Academy of Family Physicians, the United States Preventive Services Task Force, American Medical Association's Guidelines for Adolescent and Preventive Services, Substance Abuse and Mental Health Services

Administration, American Psychological Association, American Academy of Pediatrics, the American College of Obstetricians and Gynecologists and the American Diabetes Association.

2. **Preventive Services:** As part of the required improvement programs, ASES has established clinical standards/guidelines for which each MCO is required to ensure preventive services and screenings are an integral part of the GHP program. This allows for better UM mechanisms and guaranteeing access to healthcare in a timely manner for the prevention of diseases and promoting health among the GHP population. In addition, the MCOs will submit an annual CMS-416 report that measures the EPSDT screening and participation rates.

3. **Care Management Program:** This program is driven towards to CM services for enrollees who demonstrate the greatest need, including those who have chronic, HCHN conditions and/or who require intensive assistance to ensure integration of PH and BH needs. The MCOs' CM systems emphasize prevention, continuity of care and coordination of care. The model of care developed by the MCOs shall include a plan to ensure that appropriate services are in place when transitioning from an emergency room visit or an inpatient stay in accordance with section 7.8.3.2 of the contract. The system will advocate for and link enrollees to services as necessary across providers and settings.

4. **Prenatal Care Program:** This program focuses on providing access to prenatal care services during the first trimester, preventing complications during and after pregnancy, and advancing the objective of lowering the incidence of low birth weight and premature deliveries. The primary attention within the program is on the promotion of healthy lifestyles and adequate pregnancy outcomes through educational workshops regarding prenatal care topics (importance of pre-natal medical visits and post-partum care), breast-feeding, stages of childbirth, oral and mental health, family planning and newborn care, among others. In addition, the program engages in the proper access and provision of those screening test during the pregnancy.

5. **Provider Education Program:** The purpose of this program is to provide an ongoing educational activity on clinical and non-clinical topics. Puerto Rico's Medicaid Agency, through its Agent, requires that the MCO provide for providers, at least 20 continuing education hours (five per quarter) on an annual basis. Delivery of the Provider Education Curriculum and schedule to the ASES is necessary for approval prior to execution and implementation of such and in accordance with 10.2.2.1.

6. **Collocation and Reverse Collocation Model:** ASES has established the "integration model" to ensure that PH and BH services are closely interconnected, ensure optimal detection, prevention, and treatment of physical and mental illness. The MCOs will ensure that PH and BH services are fully integrated, to ensure optimal detection, prevention, and treatment of PH and BH illness. The MCOs (through contracted PCPs, PMGs and other Network Providers) will focus on ensuring that both PH and BH services coordinated with a continuity of care plan (42 CFR 438.208(b)) with case managers as the gateways between the Enrollees and the primary care services.

7. **Health Information Systems**: The ASES Information System has under gone transformation for an Underwriting and Actuarial Database Implementation. The Med-Insight project was designed to transform data into knowledge, using Milliman, Inc. proprietary relational database tools to perform analysis and reporting with the capability to extract and provide multidimensional views of the data. The Milliman MedInsight® system offers a suite of products designed to work together to provide a complete data reporting and analysis solution. With MedInsight®, ASES can perform the following functions:

- Consolidate all data information from all payers.
- Monitor profitability at contracted MCO level.
- Monitor prompt payment to providers.
- Measure and benchmark contracted MCO performance.
- Audit claim overpayments.
- Accurately display and monitor cost trends.
- Identify and track diseases, disease treatment patterns, and cost of diseases.
- Support medical and epidemiological studies.
- Build projected budgets.
- Model program and benefit changes.

In compliance with federal regulation 438.242, ASES requires that all MCOs must maintain system hardware, software, and information system resources sufficient to provide the capability to accept, transmit, maintain and store electronic data and enrollment files; accept, transmit, process, maintain and report specific information necessary to the administration of the GHP program, including, but not limited to, data pertaining to providers, enrollees, Claims, Encounters, Grievance and Appeals, disenrollment HEDIS and other quality measures. MCOs' information systems must comply with the most current federal standards for encryption of any data that is transmitted via the internet by the MCOs or its subcontractors and transmit electronic Encounter Data to ASES according to Encounter Data submission standards.

A. **Medicaid Management Information System (MMIS)**: Puerto Rico has initiated a project to improve the health of individuals, families and communities through the meaningful use of health information technology and health information to strengthen clinical decision-making, promote appropriate health care, manage costs, and improve quality through efficient program administration to virtually integrate and coordinate health care delivery for the enrollees in government-funded healthcare programs. The MMIS project goals include the following:
    - Transform the Puerto Rico Medicaid Enterprise into an information-driven organization with access to information, down to the level of the point-of-care.
    - Fully meet the present and future information needs of the GHP program.
    - Develop infrastructure capacity, and establish business processes within the Medicaid Enterprise, to provide adequate oversight of the GHP program.
    - Increase credibility with GHP stakeholders and CMS. This tool can be accessed directly by CMS.

B. EHR Incentives

In accordance with the Federal Regulation Code under the 42 CFR 495, the American Recovery & Reinvestment Act of 2009 (ARRA) and the Health Information Technology for Economic and Clinical Health (HITECH Act) of 2009, the EHR Incentive Program has been renamed Puerto Rico Medicaid Program Interoperability Promotion (MPIPPR). The MPIPPR is in place to continue the agency's focus on improving enrollee access to health information and reducing the time and cost required of providers to comply with program requirements.

The MPIPPR has two (2) stages:

- Adopt, Implement or Upgrade – at the beginning of the program
- Meaningful Use of program

Puerto Rico launched the program on October 1, 2012. The time period for which incentives are available extend to 2021. ASES functions are to:

- Manage the implementation of the Puerto Rico EHR Incentive Program
- Support program administration, payment and reporting during:
  - Data Collection
  - Outreach support
  - Adoption Processes
  - Application and Attestation Processes
  - Payment Processes
  - Verification Processes

4
Improvement and Interventions

ASES has designed the island-wide program to improve the quality of care delivered by the MCOs for GHP enrollees while reducing costs through prevention and efficiency. The following programs are designed to drive this improvement:

1. **HCIP** provides guidance for the improvement interventions through the following four initiatives:

    A. Healthy People Initiative
    B. High Cost High Need Conditions Initiative
    C. Chronic Conditions Initiative
    D. Emergency Room High Utilizers Initiative

2. **High Utilizers Program:** Pursuant to Section 7.14 and Attachment 25 of the contract, the MCOs shall collaborate with ASES to develop and implement a High Utilizers Program, including but not limited to, providing data related to PH and BH services such as:

    A. Demographic data
    B. Utilization data from the population
    C. Real-time data from the hospitals to know every time that one of the patients in the program or patients identified as prospects for the program enters the hospital
    D. Hospital data from the hospitals using the client contracting relationship with them
    E. Authorization data from fast track process for authorizations within Plans

3. **Physician Incentive-Based Program:** This program objective is to provide incentives on cash towards the physician performance where services promote the use of medical standards that support quality improvement and reduce adverse effects in enrollee care, advance the quality initiatives supported by CMS and are not geared toward, and do not have the likely effect of, reducing or limiting services that enrollee need or may need. The MCOs will develop a physician incentive program in accordance with Section 10.7 of the Contract.

5
Patient Safety

In accordance with Section 2702 of the Patient Protection and Affordable Care Act, MCOs must have mechanisms in place to prevent payment and require Providers to report the following Provider preventable conditions:

- All hospital acquired conditions as identified by Medicare, other than deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement surgery in pediatric and obstetric patients for inpatient hospital services.

- Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient for inpatient and non-institutional services.

Additionally, to address key health issues ASES has supported the following patient safety initiatives:

- The Puerto Rico Department of Health manages the Zika program and once a pregnant women tests positive for ZIKA, the laboratory who performs the test contacts the PR-DoH ZIKA Program who monitor mom and newborn throughout the pregnancy and first months of life to ensure mom and baby receive all necessary services through the Pediatric Centers of the DoH. Medicaid MCOs are offered trainings regarding the Zika virus and services available through the PR-DoH.

- Aligned with national COVID initiatives, ASES has directed their Medicaid MCOs to offer free COVID testing for members and recently included at home/FDA approved COVID-19 testing and the promotion of COVID vaccines following the DOH directives.

6

Corrective Action Plans and Intermediate Sanctions

The goal of ASES is to work closely with its MCOs in a collaborative and proactive manner to improve the quality of care and services received. There will be, at times, a need for ASES to impose corrective action plans (CAPs), sanctions, and even contract termination if the expected quality improvement is not achieved or effective. In the event the MCOs are in default as to any applicable term, condition, or requirement of the GHP contract, and in accordance with any applicable provision of 42 CFR 438.700 at any time following the effective date of the Contract, the MCOs agree that, in addition to the terms of Section 35.1.1 of the GHP Contract, ASES may impose intermediate sanctions against the MCO for any such default in accordance Article 19 of the GHP Contract.

ASES will request CAPs from the MCOs in cases for which non-compliance or the MCO did not demonstrate adequate performance. The CAPs will require clearly stated objectives, the individual/department responsible, and time frames to remedy the deficiency. The CAPs may include but are not limited to:

- Education by oral or written contact or through required training.
- Prospective or retrospective analysis of patterns or trends.
- In-service education or training.
- Intensified review.
- Changes to administrative policies and procedures.

7
Conclusions and Opportunities

ASES is focused on driving health care improvements in the Quality Improvement Initiative Areas noted in this QMS-

These initiatives remain important as the environment within Puerto Rico demonstrates significant opportunities to continue to focus on the health of members with high-cost conditions, those with chronic conditions and ensuring healthy members have access to strong preventative care:

- Almost half of all Puerto Rican's are covered under Medicaid
- The islands experience widespread poverty
- There is significantly higher incidence of chronic illness: 49% of the population has at least one chronic condition
- Seventy-two (72) of Puerto Rico's seventy-eight (78) municipalities are deemed "medically underserved areas",[5] with 500 doctors leaving per year (pre-Hurricane Irma and Maria in 2017).
- Puerto Rico has half the rate of specialists (e.g., emergency physicians, neurosurgeons) as compared to the mainland States in critical fields.

ASES is invested in improving the integration of medical and behavioral health care as a method to increase access to care for all services. In 2015, the GHP implemented a new service model with objectives to transform Puerto Rico's health system that promotes an integrated approach to PH and BH and improves access to quality primary and specialty care services.

The GHP Colocation and Reverse Colocation integrated models of care are designed to promote an integrated physical and behavioral health care delivery system within the program's network of

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[5] Health Resources & Services Administration, May 2020

providers. In the Colocation and Reverse Colocation models, the MCOs facilitate the placement of a psychologist or other type of BH Provider in each PMG practice. In the scenario of Reverse Colocation, PH services are available to Enrollees being treated in BH settings.

The island-wide approach allows a broader reach for available Providers. The close oversight of the Quality Measures listed within in the HCIP will drive continued partnership with the MCOs and other stakeholders. Rates of the HEDIS measures continue to be lower than national benchmarks for a large percentage of the measures. ASES will focus improvement on increasing fistula use for enrollees at-risk for dialysis, a clinical care project in the area of BH, an administrative project in the area of EPSDT screening, and an administrative project in the area of reverse co-location and co-location of PH and BH and their integration, providing the opportunity to identify and monitor strategies for the prevention of these chronic diseases. Lessons learned from the PIPs will continue to be incorporated into Puerto Rico's QMS.

In addition, ASES will also continue to work on improving PH and BH outcomes and access to care. ASES has been conducting audits on integrated healthcare model and as part of the CAPs identified will be enforcing this requirement.

Appendix A

Health Care Improvement Program- List of Quality Measures for each Initiative Area

HCIP Initiative Area	Quality Measures
High Cost Conditions Cancer, End-Stage Renal Disease, Multiple Sclerosis, Rheumatoid Arthritis, Children and Youth with Special Healthcare Needs, Hemophilia, and Autism	▪ Generic Dispensing Rate ▪ PHQ-4 screening ▪ Admissions per 1000 member months ▪ ED use per1000 member months ▪ Readmission Rate ▪ Adherence to formulary medications ▪ Medication reconciliation post discharge ▪ Medication reconciliation-Annual ▪ Disease-modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
Chronic Conditions Diabetes, Asthma, Severe Heart Failure, Hypertension, COPD, Chronic Depression, Substance Use Disorders, Serious Mental Illness, ADHD,	▪ Comprehensive Diabetes Care- HbA1c, Eye Exam and Nephrology Screen Statin Use ▪ PHQ-4 screening ▪ Admissions per 1000 member months ▪ ED use per 1000 member months ▪ Readmission rate ▪ Generic dispensing rate ▪ Adherence to formulary medications ▪ Medication reconciliation post discharge ▪ Medication reconciliation- Annual ▪ Medication Management for People with Asthma ▪ Asthma Medication Ratio ▪ Controlling High Blood Pressure ▪ Adherence to anti-hypertensive (RAS Agonist) medication ▪ Follow up after Hospitalization for Mental Illness 7 days and 30 days ▪ Follow up after ED visit for Mental Illness ▪ Use of Opioids at High Dosage ▪ Use of Opioids from Multiple Providers ▪ Anti-depressant Medication Management ▪ Follow up after ED Visits for Alcohol and Other Drug Abuse or Dependence ▪ Adherence to treatment (12 months) ▪ Inpatient Admissions ▪ Follow up care for children prescribed ADHD medication
Healthy People	▪ Adult BMI Assessment ▪ Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents ▪ Childhood Immunization Status ▪ Breast Cancer Screening ▪ Cervical Cancer Screening ▪ Chlamydia Screening ▪ Colorectal Screening ▪ Anti-depressant Medication Management ▪ Diabetes screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications ▪ Follow up after Hospitalization for Mental Illness: 30 Days ▪ Appropriate Treatment for Children with Upper Respiratory Infection ▪ Adults Access to Preventative/Ambulatory Health Services ▪ Children and Adolescent Access to Primary Care Practitioners ▪ Annual Dental Visit

	• Prenatal and Postpartum Care: Timeliness of Prenatal Care, Postpartum Care, Frequency of Ongoing Prenatal Care • Well-Child Visits first 15 months • Adolescent Well Care Visits • Frequency of selected procedures • Ambulatory Care • Identification of Alcohol and other Drug Services • Overall Mental Health (MH) Readmission Rate • MH Admissions per 1000 member months • MH use of Opioids at High Dosage • MH use of Opioids from Multiple Providers
Emergency Room High Utilizers	• ED utilization rate per 1000 members months on population with 7 or more visits to the ED