ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO
ASES

Puerto Rico Medical Assistance and Children's Health Insurance Program Managed Care Quality Strategy

Quality Strategy (QS)

Government of Puerto Rico

August 1, 2024

Glossary of Acronyms

ABD Aged, Blind and Disabled

ASES Administración de Seguros de Salud de Puerto Rico

AVF Arterial Venous Fistula

BH Behavioral Health

BHP Behavioral Health Providers

CAHPS® Consumer Assessment of Healthcare Providers and Systems

CAP Corrective Action Plan

CCIP Chronic Care Improvement Program

CDC Centers for Disease Control and Prevention

CFR Code of Federal Regulation

CHIP Children's Health Insurance Program

CM Care Management

CMS Centers for Medicare & Medicaid Services

COMP Comprehensive Oversight and Monitoring Program

COS Cost of Services

CPG Clinical Practice Guideline

CY Calendar Year

DoH Department of Health

D-SNP Dual Eligible Special Needs Plan

ED Emergency Department

EPSDT Early Periodic Screening, Diagnosis and Treatment

EMR Electronic Medical Record

EQR External Quality Review

EQRO External Quality Review Organization

ER Emergency Room

FMHP First Medical Health Plan

FPL Federal Poverty Level

GHP Government Health Plan

HCHN High Cost High Needs

HCIP Health Care Improvement Program

HEDIS® Healthcare Effectiveness Data and Information Set

HIT Health Information Technology

IS Information System

MA Medicare Advantage

MAGI Modified Adjusted Gross Income

MAO Medicare Advantage Organization

MCO Managed Care Organization

MH Mental Health

MMIS Medicaid Management Information System

MMM MMM Multi Health

MPIPPR Medicaid Program Interoperability Promotion

MSB Medical Social Board

NCQA National Committee for Quality Assurance

PBM Pharmacy Benefit Manager

PBA Pharmacy Benefit Administrator

P&T Pharmacy and Therapeutics

PCP Primary Care Physician

PDL Preferred Drug List

PH Physical Health

PI Performance Improvement

PIP Performance Improvement Project

PMG Primary Medical Group

PRMP Puerto Rico Medicaid Program

PSM Plan de Salud Menonita

QAPI Quality Assurance and Performance Improvement

QS Quality Strategy

SDOH Social Determinants of Health

SHCN Special Healthcare Needs

SMI Serious Mental Illness

SSDI Social Security Disability Insurance

SUD Substance Use Disorder

TANF Temporary Assistance for Needy Families

TBD To Be Determined

TOC Transition of Care

Triple-S Triple-S Health Plan

UM Utilization Management

WCV Well-Care Visit

Contents

Section 1
Introduction

Purpose

The Centers for Medicare & Medicaid Services (CMS), per regulation 42 CFR § 438.340(a) and 42 CFR 457.1240(e), requires Medicaid Managed Care Programs to have a quality strategy (QS) which is reviewed and updated as needed, but no less than once every three years [42 CFR 438.340(c) and 457.1240(e)]. This document is a revised version of the previous Puerto Rico QS submitted to CMS in July 2022 and includes the elements required in accordance with the Code of Federal Regulation (CFR) at 42 CFR 438.340, as required by the CMS and aligning with Puerto Rico specific quality goals and measures. This 2024 update was developed to align, where possible, with other Puerto Rico healthcare and quality initiatives and with the National Strategy for Quality Improvement in Healthcare and to demonstrate compliance with the CMS QS requirements set forth in 42 CFR 438.340.

The Puerto Rico Medicaid QS serves as a road map for Medicaid programming to advance island-wide quality of services focusing on patient-centered care ensure access to high quality health care services by the health plans. 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.

Scope and Overview of Medicaid in Puerto Rico

The QS describes programs and structures, program membership, services offered, goals and objectives, quality-related initiatives, and strategies, as well as administrative processes used to assure and monitor quality. The 2024 QS provides the framework to advance the focus on performance improvement (PI) activities by building a culture that is focused on outcomes, efficiently deploying resources, setting realistic and attainable goals and clearly communication a pathway for accountability.

A noted change to this version of the Puerto Rico Quality Strategy is the addition of the Platino Medicaid wrap around program (Platino). The Platino program provides additional coverage benefits to enrollees of Medicaid who are also eligible for Medicare (i.e. dually eligible) and are enrolled in a Medicare Advantage Organization (MAO). The oversight provided by ASES requires an understanding of the coordination needed with Medicare, the primary payor, to ensure a member centric approach while also considering non duplication of requirements. The inclusion of Platino into the Puerto Rico QS provides an overarching island-wide approach to all Medicaid covered members.

Program Structure and Authority

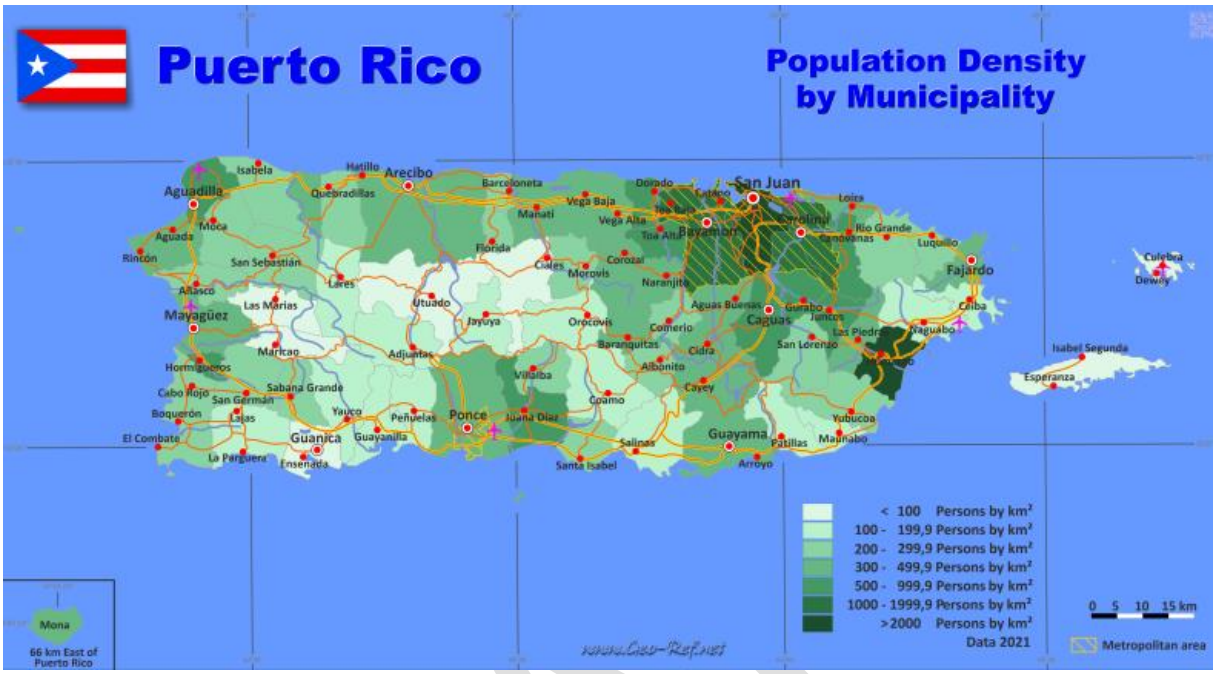
The Government of Puerto Rico's public policy states that the government has an inherent responsibility to furnish healthcare services to the Medicaid population. The public policy delineates the duties and responsibilities of the Government of Puerto Rico through its agent, Puerto Rico Health Insurance Administration [known in Spanish with its acronym as the Administración de Seguros de Salud (ASES) de Puerto Rico] to facilitate and manage the following: (1) negotiation; (2) contracting; and (3) monitoring by means of a managed care entity, which includes the quality of healthcare services.

ASES, in collaboration with the Puerto Rico Medicaid Program (PRMP), maintains the authority and responsibility for the updating the QS as required by CMS and conducting the required evaluation of the QS, and to ensure that the QS 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) or Plan Vital as well as in the Platino program. PRMP has the responsibility over enrollment, program integrity, and external quality review of the Medicaid 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 Children's Health Insurance Program (CHIP) eligibility groups. Puerto Rico does not provide Long Term Services and Supports benefits to enrollees and does not have Federally Recognized Tribes. The island has a diverse geography covering 78 municipalities, which includes a mix of urban/semi-urban, suburban, and rural areas. Please see Figure 2 for reference.

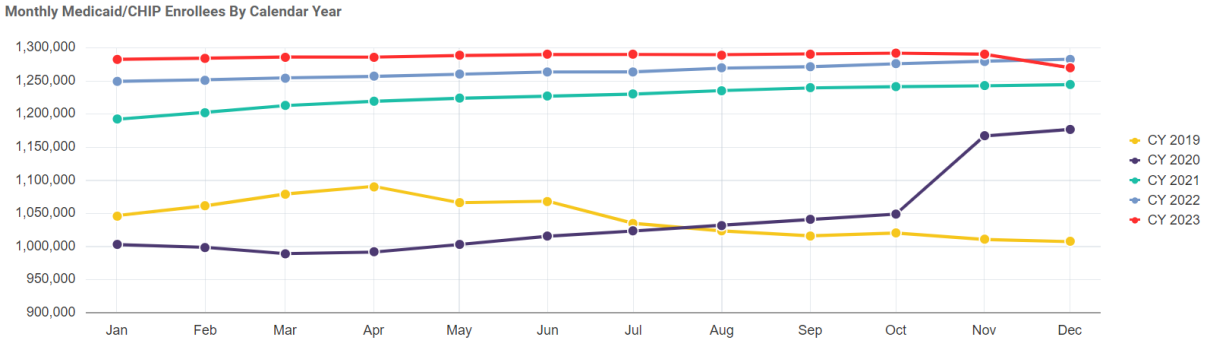
Figure 1: Puerto Rico Map with Population Density and Municipality



Puerto Rico Medicaid serves a significant percentage of the island's population with roughly 47% of all residents of Puerto Rico covered by Medicaid alone or in combination with other health insurance and nearly 62% of all Puerto Rican children covered by Medicaid[1]. Puerto Rico experienced an increase in Medicaid/CHIP enrollment during Calendar Year (CY) 2020 and CY 2021. This increase most likely is in response to the public health emergency for COVID-19 and past weather catastrophes impacting the island. Please see Figure 2 for reference.

[1] Lack of Federal Action Puts Puerto Rico and Other Territories in Peril of Dire Medicaid Fiscal Cliff, Yet Again — Center For Children and Families, Georgetown University: https://ccf.georgetown.edu/2022/10/04/lack-of-federal-action-puts-puerto-rico-and-other-territories-in-peril-of-dire-medicaid-fiscal-cliff-yet-again/#:~:text=According%20to%20data%20from%20the%20Census%20Bureau%E2%80%99s%20Puerto,of%20all%20Puerto%20Rican%20children%20had%20Medicaid%20coverage.

Figure 2: Plan Vital Monthly Medicaid/CHIP Enrollment CY 2019–CY 2023



At the close of CY 2023, the total population insured under Plan Vital was 1,270,183 with the following subcategories: Medicaid total population was 1,300,466 or 96% CHIP total population was 89,973 or 6.34% and 29,301 or 2.06% of the Commonwealth population. The Commonwealth population is comprised of individuals, regardless of age, who meet state eligibility standards established by the PRMP but do not qualify for Medicaid or CHIP. Figures 3, 4, and 5 provide reference charts illustrating the GHP population by eligible category, and Cost of Services (COS) age and gender.

Figure 3: GHP Membership by Population and COS for CY 2023

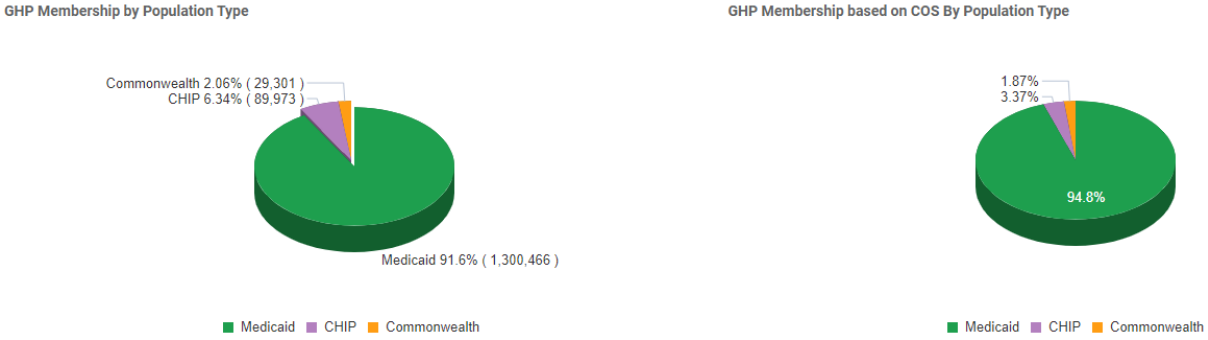
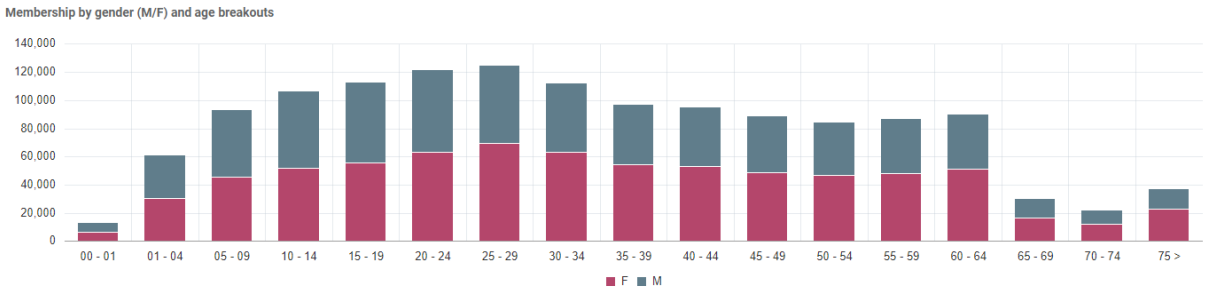


Figure 4: GHP Membership by Population and COS for CY 2023

Population Type	Membership	Total Payment	Percentage GHP Membership based on COS
Medicaid	1,300,466	$3,712,603,861.50	94.76%
CHIP	89,973	$131,984,667.10	3.37%
Commonwealth	29,301	$73,338,157.52	1.87%

Figure 5: GHP Enrollees by Age and Gender



A critical focus for improved health outcomes for Plan Vital enrollees includes consideration of the high prevalence of enrollees with one or more chronic conditions. For CY 2023, 760,380 enrollees or 54.69% of the total Plan Vital enrollment has one or more chronic condition. Please reference Figure 6. The rate of enrollees identified with a chronic condition has increased, however it is important to note that identification of enrollees with chronic conditions is through claim identification. It is unclear if there is a higher rate of enrollees with a chronic condition or if improved condition management has resulted in more accurate identification. Initiating preventative interventions and ongoing needed interventions for enrollees with these conditions is a focus of the overall QS.

Figure 6: Number of Enrollees with One or More Chronic Conditions

Program Eligibility

Eligibility in Puerto Rico differs from eligibility in the states. Puerto Rico uses a local poverty level, rather than the federal poverty level (FPL), to determine eligibility. Most Medicaid eligibility and CHIP eligibility is based on modified adjusted gross income (MAGI).

Approximately half of Puerto Rico's 3.5 million residents have low incomes and depend upon the public health system for their medical care.

PRMP maintains the process for identification of Enrollees to determine disability eligibility and governs the application, evaluation, verification, and case maintenance processes for all PRMP programs. PRMP uses the Social Security Administration (SSA) definition for disability as follows:

- **Aged:** Age 65 years of age or older.
- **Blind:** An individual age 19 through 64, with a central visual acuity of 20/200 of less in the eye with better vision with correcting glasses, or a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance of no greater than 20 degrees.
- **Disabled:** An individual under the age of 65 who has a physical and/or mental health impediment of loss that is expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months and precludes them from engaging in substantial gainful activity.

Disability determination of can be made through a PRMP case worker or the case worker must use the blind and disabled determination of another qualified agency. For aged, the case worker must verify the individual’s age by Social Security records or by documents in the individual’s possession such as a driver’s license, birth certificate, or passport. For blind or disabled disability determination, the case worker verifies the individual’s blindness or disability using the following:

- Certification or other official document from the SSA that shows that the person is classified as blind or disabled,
- Evidence that the applicant is a current beneficiary of the Temporary Assistance for Needy Families (TANF) – Aged, Blind, and Disabled (ABD) Program under the disabled category or,
- Determination of disability or blindness by the Medical Social Board (MSB).

PRMP uses data sources from both the Federal and State Hubs. The Eligibility and Enrollment system receives information regarding the disability from these two sources as described below:

- **Federal Data Services Hub:** SSA Administration Title 8. exchange providing information regarding the disability information. Including the effective date and end date if applicable.
- **Administración de Desarrollo Socioeconómico de la Familia (ADSEF):** Exchange providing information regarding the TANF benefit for member with an active disability on their data base.

Contracted Entities

Plan Vital

Plan Vital program and services are administered through 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.

There are four Medicaid MCOs, contracted for the management of Plan Vital (Figure 7). MCO contracting recently went through a re-procurement and the start of the new contract was executed January 2023. Through contractual agreement with these MCOs, the GHP provides a health insurance system that furnishes access to covered services for 100% of Puerto Rico's Medicaid population. 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[2].

Platino

ASES maintains contracts with four MAOs (Figure 7) for the management and coordination of Medicaid wrap around services for members who are dually eligible for Medicare and Medicaid. Medicaid covered services for Platino members are limited to wrap around services that complement Medicare Advantage (MA) benefits. Individuals who are eligible for both Medicare and Medicaid must enroll in a MAO for the coordination of their Medicaid benefits, and many those individuals also enroll in the MA product for their Medicare benefits. This coordination encourages an enrollee centric approach to care where services, whether through Medicare or Medicaid, is seamless to the enrollee. ASES updates the Medicaid wrap around contract with each of the four MAOs on an annual basis.

Pharmacy Benefit Manager

ASES contracts directly with Abarca, a Pharmacy Benefit Manager (PBM) vendor for the Plan Vital program (Figure 7), with direct monitoring and oversight. The Platino MAOs manage pharmacy benefits, contracting with delegated entities for PBM services.

[2] Quality of Care in Puerto Rico — Medicaid.gov: https://www.medicaid.gov/state-overviews/puerto-rico.html.

Figure 7: Plan Vital MCOs, Platino MAOs, and Plan Vital PBM

Plan Vital MCOs	Platino MAOs	Plan Vital PBM
•First Medical Health Plan (FMHP) •MMM Multi Health (MMM) •Plan de Salud Menonita (PSM) •Triple S Health Plan (Triple S)	•Humana •MCS •Triple-S Advantage • MMM Healthcare	•Abarca

Section 2

Quality Program

Evolution of the Quality Strategy

As a Part of Puerto Rico's continuous quality improvement, there have been several updates and changes through contractual changes, evaluation of the Medicaid program, and revision of the Puerto Rico QS. Below is a high-level overview illustrating the evolving quality improvement program in Puerto Rico Medicaid.

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 Co-location and Reverse Co-location integrated models of care are designed to promote an integrated physical and behavioral healthcare delivery system within the program's network of providers. In the Co-location and Reverse Co-location models, the MCOs facilitate the placement of a psychologist or other type of BH Provider in each Primary Medical Group (PMG) setting. PMGs are a grouping of primary care physicians (PCPs) and other providers who use a coordinated care model. In the scenario of Reverse Co-location, PH services are available to enrollees being treated in BH settings. This integrated model has been in place and improved upon since inception.

In 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. ASES has an island-wide approach facilitating access for all members throughout the island and allowing the MCOs to establish a wide network of providers. MCOs are responsible for ensuring continued care and provider access for enrollees transitioning between MCOs in accordance with the Plan Vital Model Contract and 42 CFR 438.62.

In 2022, ASES contracted with a single PBM for all clinical and financial services related to the pharmacy benefit. Some of the advantages realized with moving to a single contract was streamlining contract services, communication and oversight, and improved pricing. The MCOs have been obligated to establish a working relationship with the PBM to ensure seamless pharmacy services to Plan Vital members. The MCOs are responsible for clinical prior authorizations of the pharmacy services and coordinate other drug UM initiatives with ASES and the PBM. The prescription drug costs are included in the managed care capitation rate, and the MCOs are fully at-risk for the medical portion of pharmacy expenditures.

In 2023, ASES updated the MCO Plan Vital contracts which included changes to the Health Care Improvement Program (HCIP). The new contract had a greater focus on prevalent chronic conditions identified within the population which are included in the HCIP. These changes are detailed within the HCIP incentives section.

In 2024, ASES realized the importance of aligning the island wide Puerto Rico QS not only for the Plan Vital enrollees but also to include the Platino enrollees. There are areas of overlap between Plan Vital and Platino. For instance, many providers are in network and provide services to enrollees from both Plan Vital and Platino. For instance, many providers are in network for both and provide services to enrollees from both Plan Vital and Platino. Therefore, ASES added Platino membership to be included in the 2024 QS to provide a consistent vision across the island and to streamline initiatives.

Quality Strategy Feedback and Evaluation Process

The QS 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 QS will be reviewed and updated no less than once every three years. ASES will achieve this ongoing review and evaluation through reporting, oversight, and monitoring of the MCOs and MAOs through its External Quality Review Organization (EQRO). PRMP has contracted with Mercer as the EQR vendor. ASES will submit a revised QS at any point if there is a significant change as a result of the ongoing review and evaluation. Puerto Rico defines a significant change as major program changes (i.e., new/change in services, new/change in populations) or a change in any of the program goals. Public input is utilized for any resubmission of the QS to CMS.

In accordance with 42 CFR 438.340(c)(1), Plan Vital enrollees, the general public, and stakeholders are provided the opportunity to provide input and recommendations regarding the content and direction of the QS. The QS is posted on the ASES website for a 30-day period, https://site-modules-master-d9ab073bd1970c34a98.webflow.io/informes-regulatorios?tab=InformesCongreso#Informes, with public notice requesting public feedback via the ASES quality department email (asesquality@ases.pr.gov). The final QS will be posted to the ASES website once any edits or changes are incorporated from the feedback received.

ASES will continue to seek participant and family/guardian, stakeholder, and public input into the review and evaluation of the QS 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 Plan Vital program. ASES will incorporate recommendations from enrollees, the general public, MCOs, the EQRO and other stakeholders in setting new goals and revising the QS 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 identified indicators levering reports used to assess MCO quality performance and effectiveness of the QS through ongoing monitoring efforts and oversight of the MCOs.

Framework for Quality Improvement

ASES embeds quality improvement activities throughout its cross-cutting programs and operations. Strategic initiatives, including value-based purchasing requirements, directed

payments, contractual requirements for its MCOs, performance improvement projects (PIPs), and other strategies, drives quality improvement of its contractors to support the programs goals and objectives.

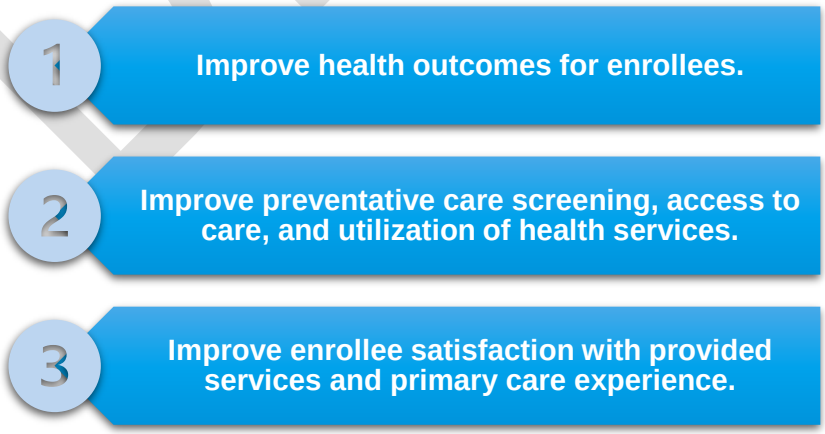
The QS establishes the framework for improving access, timeliness, and quality of healthcare through performance improvement activities, monitoring, and evaluating health quality measures, such as the Health Care Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers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

- Promote wellness for healthy populations to remain healthy and avoid progression to chronic conditions.
- Increase coordination between the enrollee's healthcare needs and all treating providers.
- Ensure enrollees with special healthcare needs (SHCN), those with Serious Mental Illness (SMI) or Serious Emotional Disturbance and enrollees who have accessed the emergency department (ED) seven or more times in the last 12 months are populations of focus for the MCO CM programs.

Goals and Objectives

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 overarching goals driving the QS for Puerto Rico are shown in Figure 8. Below:

Figure 8. Goals and Objectives of QS



The goals and objectives address, and are sensitive to, special needs populations and outline the requirements in terms of services, deliverables, performance measures, and health outcomes within the contract. As mentioned, ASES has contracted with MCOs and MAOs to partner and deliver on the quality goals and objectives. ASES' regular and consistent review of the QS will highlight progress toward goals and measures and related MCO and MAO 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.

ASES recognizes that effective quality improvement must be methodical, ongoing, and measurable. For the QS, a mix of quantitative and qualitative measures have been identified to monitor clinical quality, access, and utilization management 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 QS.

Table 1 below provides the linked goals, objectives, and metrics. The table also indicates whether an objective relates to an approved State Directed Payment arrangement.

Table 1: Goals, Objectives, and Targets

Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (CY 2024)
Goal 1: Improve Health Outcomes for Enrollees			
Increase the number of enrollees that receive hemoglobin A1c (HbA1c) testing	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing comply or exceed the benchmark.	2021 Benchmark: 77.68%	Complying with or exceeding benchmark
Decrease the number of enrollees with hemoglobin A1c (HbA1c) poor control (>9.0%)	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c control for patients with diabetes (HBD),	2019 Benchmark: 70.94%	Complying with or exceeding benchmark or lower than 68.94% (lower is favorable)

Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (CY 2024)
	poor control (>9.0%) meets or is lower than benchmark or has a 2% reduction over baseline. **Directed Payment:** Increasing access and availability for capitated primary care providers		
Decrease the number of enrollees with diabetes who had blood pressure control (<140/90 mm Hg)	The percentage of enrollees 18–75 years of age with diabetes (type 1 and type 2) who had blood pressure control for patients With Diabetes (<140/90 mm Hg) that comply with or is lower than benchmark.	2021 Benchmark: 30.73%	Complying with or exceeding benchmark (lower is favorable)
Increase the number of enrollees with diabetes that receive an eye exam	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had eye exam comply with or exceeds the benchmark.	2021 Benchmark: 26.17%	Complying with or exceeding benchmark
Increase the number of enrollees with diabetes that receive a kidney health evaluation for patients with diabetes	The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio	2021 Benchmark: 12.05%	Complying with or exceeding benchmark

Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (CY 2024)
	(uACR), during the measurement year that comply with or exceeds the benchmark.		
PQI 01: Diabetes Short Term Complications Admission Rate, reduction of admissions	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 target Diabetes Short Term Complications population, ages 18 years and older that comply with or is lower than benchmark.	2021 Benchmark: 71%	Complying with or exceeding benchmark (lower is favorable)
PQI 15: Asthma in Younger Adults Admission Rate, reduction of admissions	Admissions for a principal diagnosis of asthma per 100,000 target Asthma in Younger Adults population, ages 18–39 years that comply with or is lower than benchmark.	2021 Benchmark: 47%	Complying with or exceeding benchmark (lower is favorable)
Reduction of members with asthma that present to the ED	For members 18 years of age and older, the number of observed ED visits for asthma during the measurement year per 1,000 eligible population with asthma that comply with or is lower than benchmark.	2021 Benchmark: 104%	Complying with or exceeding benchmark (lower is favorable)
Increase in the number of enrollees with	Members with asthma who were screened	2021 Benchmark: 16.08%	Complying with or exceeding benchmark

Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (CY 2024)
asthma that are screened using a PHQ-9	with a PHQ-9 test during the measurement period that comply with exceed the benchmark.		
PQI 08: Heart Failure Admission Rate, reduction of admissions	Admissions with a principal diagnosis of heart failure per 100,000 target Heart Failure population, ages 18 years and older (AHRQ PQI).	2021 Benchmark: 174%	Complying with or exceeding benchmark (lower is favorable)
Increase in the number of enrollees with heart failure that are screened using a PHQ-9	Members who were screened with a PHQ-9 test during the measurement period that comply with exceed the benchmark.	2021 Benchmark: 24.24%	Complying with or exceeding benchmark
Reduction of members with hypertension that present to the ED	For members 18 years of age and older, the number of observed ED visits for hypertension during the measurement year per 1,000 eligible population with hypertension that comply with or is lower than benchmark.	2021 Benchmark: 74%	Complying with or exceeding benchmark (lower is favorable)
PQI 05: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate, reduction of admissions	Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per target COPD or Asthma in Older Adults 100,000 population,	2021 Benchmark: 190%	Complying with or exceeding benchmark (lower is favorable)

Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (CY 2024)
	ages 40 years and older that comply with or is lower than benchmark.		
Increase of follow up after hospitalization for mental illness: seven days for enrollees with select mental health (MH) conditions (chronic depression/ mania/bipolar disorder)	The percentage of discharges for members six years of age and older who were hospitalized for treatment of chronic depression/mania/ bipolar disorder who had a follow-up visit with a MH practitioner within seven days of discharge that comply with exceed the benchmark.	2021 Benchmark: 45.71%	Complying with or exceeding benchmark
Increase of follow up after hospitalization for mental illness: 30 days for enrollees with select MH conditions (chronic depression/ mania/bipolar disorder)	The percentage of discharges for members six years of age and older who were hospitalized for treatment of chronic depression/mania/ bipolar disorder who had a follow-up visit with a MH practitioner within 30 days of discharge that comply with exceed the benchmark.	2021 Benchmark: 73.15%	Complying with or exceeding benchmark

Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (CY 2024)
Decrease of admissions for enrollees with chronic depression/mania/ bipolar disorder	For members 18 years of age and older, the number of admissions for chronic depression/ mania/ bipolar disorder during the measurement year per 1,000 eligible population with a principal diagnosis (ICD-10-CM) of chronic depression/ mania/ bipolar disorder comply with or are lower than benchmark.	2021 Benchmark: 72%	Complying with or exceeding benchmark (lower is favorable)
Decrease of PH ED visits	ED utilization rate x 1,000 with PH primary diagnoses comply with or are lower than benchmark. **Directed Payment:** Increase access and availability of urgent care centers.	2022: To be determined	Complying with or exceeding benchmark (lower is favorable)
Decrease of ED visits for enrollees identified as high ED utilizers	Emergency Room utilization rate x 1,000 on identified population with seven or more visits to the emergency room comply with or are lower than benchmark.	2021 Benchmark: 897%	Complying with or exceeding benchmark (lower is favorable)

Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (CY 2024)
Goal 2: Improve Preventative Care Screening, Access to Care and Utilization of Health Services			
Increase of enrollees receiving breast cancer screening	Increase in the percentage of women 50–74 years of age receiving a mammogram to screen for breast cancer that complies with or exceed benchmark.	2021 Benchmark: 50.88%	Complying with or exceeding benchmark

Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (CY 2024)
Increase of enrollees receiving cervical cancer screening	Increase in the percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women 21–64 years of age who had cervical cytology performed within the last three years • Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last five years (HEDIS) That complies with or exceeds the benchmark.	2021 Benchmark: 50.57%	Complying with or exceeding benchmark

Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (CY 2024)
Increase of enrollees that have controlled high blood pressure	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year that comply with or exceeds the benchmark.	2021 Benchmark: 31.77%	Complying with or exceeding benchmark
Increase of diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications.	The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year that comply with or exceeds the benchmark.	2021 Benchmark: 60.07%	Complying with or exceeding benchmark
Increase in follow-up after hospitalization for mental illness: 30 days	The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm diagnoses and who had a follow-up visit	2021 Benchmark: 73.77%	Complying with or exceeding benchmark

Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (CY 2024)
	with a MH practitioner within 30 days that comply with or exceeds the benchmark. **Directed Payment:** Increase of access and availability for specialists and sub-specialists.		
Increase in adults' access to preventive/ ambulatory health services	The percentage of members 20 years and older who had an ambulatory or preventive care visit that comply with or exceeds the benchmark. **Directed Payment:** Increasing access and availability for capitated primary care providers.	2019 Benchmark: 2% improvement or complying with 75% benchmark	Complying with or exceeding benchmark
Increase in oral evaluation, dental services (replaced Annual Dental Visit)	Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year that comply with or exceeds the benchmark. **Directed Payment:** Increase access and availability for dental services.	2021 Benchmark: 44.12%	Complying with or exceeding benchmark

Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (CY 2024)
Increase of timeliness of prenatal care	The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization that comply with or exceeds the benchmark.	2021 Benchmark: 58.05%	Complying with or exceeding benchmark
Increase of timeliness of postpartum care	The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery that comply with or exceeds the benchmark.	2021 Benchmark: 42.53%	Complying with or exceeding benchmark
Increase of well-child visits in the first 30 months of life	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: • Well-Child Visits in the first 15 months. Children who turned 15 months old during the measurement year: Six or more well-child visits. • Well-Child Visits for age 15–30 months.	2021 Benchmark: 0-15 months: 4.03% 15–30 months: 23.55%	Complying with or exceeding benchmark

Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (CY 2024)
	Children who turned 30 months old during the measurement year: Two or more well-child visits that comply with or exceeds the benchmark.		
Increase of child and adolescent well-care visits	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year that comply with or exceeds the benchmark or demonstrates a 1% increase. **Directed Payment:** Increase access and availability of other physicians and laboratory services.	2018 Benchmark: 53.2%	Complying with or exceeding benchmark or 1% increase
Reduction of Inpatient BH and PH Admissions	Reduce PH Inpatient admissions/1,000 by 2%. **Directed Payment:** Increase access and availability of Short-term Acute Hospitals (STAC).	2019 baseline: 56.35	Complying with or exceeding benchmark of 54.35 PH admissions/1000 (lower is favorable)

Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (CY 2024)
	Reduce BH Inpatient admissions/1,000 by 2%. **Directed Payment:** Increase access and availability of STAC.	2019 baseline: 6.31	Complying with or exceeding benchmark of 4.31 BH admissions/1000 (lower is favorable)
Reduction of Inpatient BH and PH Readmissions	Reduce PH Inpatient re-admissions/1000 by 0.5% **Directed Payment:** Increase access and availability of STAC.	2019 baseline: 4.74	Complying with or exceeding benchmark of 4.24 PH re-admissions/1000 (lower is favorable)
	Reduce BH Inpatient readmissions/1,000 by 0.1%. **Directed Payment:** Increase access and availability of STAC.	2019 baseline: 0.68	Complying with or exceeding benchmark or lower than 0.58 BH readmissions/1,000 (lower is favorable)
Goal 3: Improve Enrollee Satisfaction with Provided Services and Primary Care Experience			
Increase in the CAHPS Experience of Care and Health Outcomes Survey (ECHO) metric: Getting Treatment Quickly	Increase in the CAHPS Experience of Care and Health Outcomes Survey (ECHO) metric: Getting Treatment Quickly by 1%. **Directed Payment:** Increase of access and availability for specialists and sub-specialists.	2020 baseline: FMHP: 70% MMM: 73.8% PSM: 66.1% Triple-S: 71.6%	1% improvement: FMHP: 71% MMM: 74.8% PSM: 67.1% Triple-S: 72.6%
Increase in the patient experience using CAHPS Survey	Increase in the patient experience using CAHPS Survey Indicator metric: Adult	2021 baseline: FMHP: 78.5% MMM: 77.8%	2% improvement over baseline or meet 85%: FMHP: 80.5% MMM: 79.8%

Objective	Measure/Target	Statewide Performance Baseline (Year)	Statewide Performance Target for Objective (CY 2024)
Indicator metric: Adult Getting Needed Care	Getting Needed Care 2% improvement over baseline or meet 85%. **Directed Payment:** Increase of access and availability for capitated primary care providers.	PSM: 77.2% Triple-S: 80.7%	PSM: 79.2% Triple-S: 82.7%
Increase in the CAHPS Experience of Care metric: Specialists Appointment (Adult)	Increase in the CAHPS Experience of Care metric: Specialists Appointment (Adult) 5% improvement over baseline. **Directed Payment:** Increase of access and availability for specialists and sub-specialists.	2021 baseline: FMHP: 75.2% MMM: 78% PSM: 74.1% Triple-S: 79.2%	2% improvement over baseline: FMHP: 80.2% MMM: 83% PSM: 77.1% Triple-S: 82.2%

Section 3
Quality Strategy Initiatives

The Puerto Rico managed care programs advance prioritized initiatives that relate directly back to the ASES goals of improving health outcomes, preventative care screening, access to care and utilization of health services, and enrollee satisfaction. This section provides a description of initiatives set forth in Puerto Rico to support the goals of the Medicaid Quality Program.

Health Equity

In accordance with 42 CFR § 438.340, Puerto Rico is working to identify, as part of their quality strategies efforts to "identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status". Puerto Rico is using the CMS Health Equity toolkit (CMS Framework for Health Equity 2022-2032 [https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf]) to identify priorities to reduce disparities in Health. Puerto Rico has unique health equity 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 natural disasters.

- To reduce health equity issues for the rural Islands of Culebra and Vieques, Puerto Rico has implemented "Preferential Turns" for residents of these municipalities. This initiative requires the MCOs and MAOs to develop a process where enrollees from these islands are able to be seen in a priority order due to the distance they are required to travel for services.
- Expand the collection, reporting, and analysis of standardized data. Age, race, ethnicity, gender, rural/urban, and preferred language are examples of the demographic data included when stratifying enrollees. Puerto Rico will use stratification of performance measures in reporting to develop strategies and interventions for the prevention of the most prevalent conditions, while identifying health equity concerns.
- Puerto Rico receives quarterly geographical network access reports from the MCOs which is used to monitor island wide access ongoing. The EQRO also reviews and validates Plan Vital network access annually. Using the data from these reports, Puerto Rico can identify areas in need of additional providers and partner with MCOs/MAOs and other stakeholders to increase capacity for healthcare workforce and targeting areas identified with potential healthcare disparities.
- The MCOs and MAOs include a review of accessibility for provider offices on a routine basis. Required service location updates are communicated and monitored to ensure

universal access. They must also ensure that they are seeking new providers in any service areas that have a gap in coverage.

Health Care Improvement Program

The HCIP is one of the tools developed by ASES, specific to Plan Vital, to drive quality improvement of the MCOs and support the program's overarching goals and objectives. The HCIP is a financial withhold through a retention fund where MCOs earn incentives based on achieving benchmark targets established by ASES for quality measures identified within each initiative category. The HCIP program replaces Disease Management and other less effective methods and holds the MCOs financially responsible for meeting prescribed outcome measures. MCOs are required to track and report on each of the three HCIP initiative categories that are listed below and report all HCIP quality measures quarterly.

- **Healthy People Initiative:** The Healthy People Initiative focuses on preventive screening for all enrollees, including populations identified chronic conditions.
- **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.
- **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.

In 2023, after careful review and consideration, ASES eliminated a fourth category which was a separate and distinct focus on High-Cost High Needs (HCHNs). HCHNs historically were enrollees who were frequently included in the remaining other three initiatives and/or under the special coverage program. Therefore, eliminating the HCHNs initiative allowed for a more streamlined inclusive approach.

The table below provides a high-level summary of the three HCIP initiatives:

Table 2: HCIP Initiatives

HCIP Initiative Area	Description	Quality Measures
Healthy People	The Healthy People Initiative focuses on preventive screening for all enrollees, including populations identified with chronic conditions.	11 Quality Measures—Mix of Adult and Child and mix of Medical and BH

HCIP Initiative Area	Description	Quality Measures
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 an ensure access to required services.	16 Quality Measures — Mix of Adult and Child and mix of Medical and BH
Emergency Room (ER) High Utilizers	The ER High Utilizers Initiative is designed to identify high users of emergency services (including BH) for non-emergency conditions.	One Quality Measure focused on ER utilization for high utilizers of ER services

Member and Provider Satisfaction

Member perspective provides important information about how the program is working to improve member health and whether services are accessible. For Plan Vital, ASES contractually requires all MCOs to conduct a member satisfaction survey on at least an annual basis. The survey tools required are:

- CAHPS Health Plan Survey, Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items
- CAHPS Health Plan Survey, Adult Version
- CAHPS ECHO Survey

The standardized survey tools include questions designed to assess specific dimensions of client satisfaction with providers, services, delivery, and quality, including but not limited to:

- Overall satisfaction with MCO services, delivery, and quality.
- Member satisfaction with the accessibility and availability of services.
- Member satisfaction with quality of care offered by the MCO's providers. To capture insights of the Plan Vital program, ASES requires a Provider Satisfaction Survey Report to capture survey activities of Physical and BH Network Providers. This report does not have a prescribed survey instrument.

Performance Improvement Programs

Consistent with 42 CFR § 438.330(d), ASES requires its Plan Vital MCOs to conduct PIPs to achieve sustained improvement in health outcomes and beneficiary satisfaction as well as access, quality, and timeliness of care. At a minimum, the topics of the PIPs are:

- One clinical care project in the area of improving kidney health evaluation rates in order to identify early stages of decreased kidney function.
- One clinical care project in the area of increasing screening for depression, anxiety, substance use disorder (SUD) for all covered populations using nationally recognized screening tools.
- One clinical care project designed to improve the outcomes for enrollees with diabetes.
- One administrative project in the area of EPSDT.
- One administrative project in the area of reverse co-location and co-location of PH and BH and their integration.

ASES expects its contracted MCOs to manage effective PIPs that demonstrate the ability to develop and execute effective projects in alignment with ASES' overarching QS goals and the HCIP initiatives. Through the use of PIPs, ASES is looking to see that MCOs develop quality improvement projects that demonstrate measurable quality improvement. MCOs are required to manage and implement an ongoing program of PIPs that focus on clinical and non-clinical areas. Federal requirements mandate states perform validation of PIPs conducted. ASES' performs PIP validation and additionally requires MCOs to submit PIPs proposed for the upcoming year for review, feedback, and approval. Additionally, ASES requires MCOs submit all PIP descriptions and program details annually as part of the Quality Assurance and Performance Improvement (QAPI) program description.

ASES relies on the expertise of its contracted MCOs to develop strong aim statements and interventions that align with the overarching QS goals to improve access, quality, and timeliness of care for MCO enrollees. The EQRO also reviews the PIPs each year to validate the required elements and improvement. PIPs must be designed to achieve significant improvement in health outcomes and enrollee satisfaction, and include the following elements:

- Study area that is based on comprehensive evaluation of need and is expected to achieve measurable benefits to enrollees.
- Clear, defined, and measurable goals and objectives that can be achieved each year of the project.
- Measurement of performance using objective quality indicators that allow performance tracking over time.
- Implementation of interventions that are specifically designed to achieve the quality improvements outlined in the PIP.

- Rapid-cycle improvement processes to evaluate the effectiveness of the interventions and adjust accordingly.
- Standardized performance measures whenever possible to prioritize the use of CMS Adult and Child Core Set Measures.
- Activities planned for increasing or sustaining improvement.
- Data collection methodology used to assure data is valid and reliable.

Table 3 Summary of MCO 2022 PIP Topics, Aims, and Interventions

Plan Vital			
QS Goal	**PIP Topic**	**PIP Aim**	**PIP Interventions**
FHMP			
Goal 1: Improve Health Outcomes for Enrollees	Improve Kidney Health Evaluation	Achieve an improvement (any) in kidney health evaluation rates and related measures in diabetic population of 18–85 years considered at risk for kidney chronic disease stage 1 or stage 2 for 2024 and 2025 using as a baseline the 2023 results of the measures identified for this PIP. For measures that have PHRIA baseline, the compliance with the baseline or any improvement from this baseline.	• Developed educational activities to target members through different departments (Medical Affairs, CM, Quality, Pharmacy, Education) and delivery of educational material to eligible members. • Implemented gaps in care alerts (using outbound automatic calls and text messages) to eligible members to improve their compliance with the preventive tests and management of their health and conditions. • Developed and distributed materials related to FMHP QAPI Program, and its related PIPs to providers. • Linked CM programs to promote AVF education in members at high risk for dialysis.
Goal 2: Improve Preventative Care Screening, Access to Care and Utilization of	Increase Screening for Depression, Anxiety, SUD Screening	Achieve the increase of screenings (any increase) rates for Depression, Anxiety, Substance Use for the population of 18 years or older responding the Screening Tools PHQ-9 (for depression), GAD-7 (anxiety) and CAGE – AID (drug and	• Developed and implemented educational activities to target members. • Distributed educational materials to targeted members.

Plan Vital			
QS Goal	**PIP Topic**	**PIP Aim**	**PIP Interventions**
Health Services		alcohol use disorder) as established in the Article 12 of the ASES Contract for 2024 and 2025 using as a baseline the FMHP 2023 results of the measures identified for this PIP.	• Developed and distributed materials related to FMHP QAPI Program, and its related PIPs to providers.
Goal 1: Improve Health Outcomes for Enrollees	Improve Outcomes for Enrollees with Diabetes	Achieve an improvement (any) in HEDIS Comprehensive Diabetes Care Measures rates, in diabetic population (diabetes type 1 or 2) of 18–85 years for 2024 and 2025 using as a baseline the 2023 results of the measures identified for this PIP. For measures that have PHRIA baseline, the compliance with the baseline or any improvement from this baseline.	• Developed educational activities to target members through different departments (Medical Affairs, CM, Quality, Pharmacy, Education) and delivery of educational material to eligible members. • Implemented gaps in care alerts (using outbound automatic calls and text messages) to eligible members to improve their compliance with the preventive tests and management of their health and conditions. • Developed and distributed materials related to FMHP QAPI Program, and its related PIPs to providers.
Goal 2: Improve Preventative Care Screening, Access to Care and Utilization of Health Services	Improve EPSDT Screening Rates	Achieve an improvement (any) in the CMS 416 Participation Ratio and Screening Ratio for 2024 and 2025 using as a baseline the 2023 results of the CMS 416 for FMHP population of 0–21 years. For Well-Child Visits measures (0–15 months and 15–30 months) and Child and Adolescent Well-Care (3–21 years) visits that have PHRIA baseline for 2023, achieve compliance with the PHRIA baseline or any improvement from this baseline in 2023, 2024, and 2025.	• Developed educational activities to target members through different departments (Medical Affairs, CM, Quality, Pharmacy, Education) and delivery of educational material to eligible members. • Implemented gaps in care alerts (using outbound automatic calls and text messages) to eligible members to improve their compliance with the preventive tests and management of their health and conditions.

Plan Vital			
QS Goal	**PIP Topic**	**PIP Aim**	**PIP Interventions**
			• Developed and distributed materials related to FMHP QAPI Program, and its related PIPs to providers.
Goal 1: Improve Health Outcomes for Enrollees	Increase Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health	By December 31, 2023, we aim to increase the percentage of case discussions between the PCP and BH providers of initial patients that receive services in the primary groups by 3% of 27 % (2022 result) during the year.	• Solicitated input from members through evaluation and screening. • Tailored communication to individual member needs. • Provided discharge summaries for transitioning patients. • Enhanced communication between PCPs and Behavioral Health Providers (BHPs). • Advocated for integrated care and utilized standardized documentation and integrated Electronic Medical Records (EMR) systems.
MMM			
Goal 1: Improve Health Outcomes for Enrollees	Improve Kidney Health Evaluation	Will interventions with providers and beneficiaries focused in managing risk in beneficiaries at risk of kidney disease improve kidney health screening and blood pressure control over a three-year period?	• Developed educational materials. • Conducted face-to-face visits with PCPs. • Developed provider bulletins.

Plan Vital			
QS Goal	**PIP Topic**	**PIP Aim**	**PIP Interventions**
Goal 2: Improve Preventative Care Screening, Access to Care and Utilization of Health Services	Increase Screening for Depression, Anxiety, SUD	Will the orientation to providers and members implemented improve the screening for depression and follow-up plan among beneficiaries ages 12 and older over a three-year period?	• Facilitated meetings with MH clinics. • Coordination for information sharing by MH clinics and by MH and health services case management. • Distribution and orientation/awareness of screening tools. • Presented to the Advisory Board on specific themes (e.g., MH screenings in primary care setting, early identification, and risk factors). • Implemented and promoted My Emotions icon in the MMM application.
Goal 1: Improve Health Outcomes for Enrollees	Improve Outcomes for Enrollees with Diabetes	Will interventions focused on MH screening and healthy lifestyle, improve the A1c and BP among female beneficiaries with diabetes, over a three-year period?	• Met with PMG administrative staff to develop a referral process to the collocated providers. • Implemented PHQ-9 screening process at PMG level. • Educated providers and clinical staff on Standards of Medical Care in Diabetes—2022. • Generated and disseminated provider-specific reports on diabetes measures. • Met with physicians to give feedback on measure reporting. • Developed targeted education activities focusing on nutrition, weight management, cholesterol, and exercise.

Plan Vital			
QS Goal	**PIP Topic**	**PIP Aim**	**PIP Interventions**
Goal 2: Improve Preventative Care Screening, Access to Care and Utilization of Health Services	Improve EPSDT Screening Rates	Will the use of educational material and targeted interventions of face-to-face meetings and workshops improve well child visit rates among girls from 3–8 years of age, over a three-year period?	• Developed educational materials for face-to-face interventions with providers.
Goal 1: Improve Health Outcomes for Enrollees	Increase Use of Reverse Co-Location and Co-Location of Physical and BH	Will the periodic workshops meetings with PMGs and MH clinics, decrease the emergency visits among beneficiaries with a co-occurring PH condition and substance use disorders who may benefit from Integrated physical and behavioral healthcare over a three-year period?	• Facilitated Quality workshops with PMGs. • Met with PMG administrative staff to develop a referral process to the co-located provider and implementation of the PHQ-9 screening process. • Facilitated Quality workshops with MH clinics. • Conducted face-to-face visits with PCPs to promote utilization of co-located providers.
PSM			
Goal 1: Improve Health Outcomes for Enrollees	Improve Kidney Health Evaluation	By CY 2024 PSM will increase the annual rate of Kidney Health Evaluation for Diabetics (KED) that are 18-85 years of age, at or above 3% of PSM 2022 KED benchmark.	• Developed outreach interventions for members with chronic conditions and have a gap in KED screening. • Developed text message initiative for members in need of preventive screening.
Goal 2: Improve Preventative Care Screening, Access to Care and Utilization of Health Services	Increase Screening for Depression, Anxiety, SUD Screening	By CY 2024 we aim to increase the amount of depression screenings for patients between 12–17 years in the outpatient level of care by or greater than 3% of PSM baseline (4.1%.).	• PSM is in the “Do” phase of the PDSA cycle; interventions are being outlined to be implemented in the next phases.

Plan Vital			
QS Goal	**PIP Topic**	**PIP Aim**	**PIP Interventions**
Goal 2: Improve Preventative Care Screening, Access to Care and Utilization of Health Services	Improve Outcomes for Enrollees with Diabetes	Decrease the annual rate of the A1c poor control (>9%) measure for Diabetics by 3% of PSM 2022 benchmark by the end of Contract Year 2024.	• Developed and implemented educational telephone interventions. • Developed and implemented social media posts and videos educating members. • Implemented health talks and educational information booths in PMGs offices and community outreach. • Developed and implemented educational text messages for preventive screenings. • Quarterly Gaps in Care report to PMGs.
Goal 2: Improve Preventative Care Screening, Access to Care and Utilization of Health Services	Improve EPSDT Screening Rates	Increase the annual rate of Well Child Care Visit (W30) to perform at or above 3% of PSM 2022 benchmark by Contract Year 2024.	• Provided outreach interventions to families about the importance of well child visits through the EPSDT program, including calls and letters. • Quarterly Gaps in Care report to PMGs.
Goal 1: Improve Health Outcomes for Enrollees	Increase Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health	PSM aims to increase the number of case discussions between the PCP and BH providers during the year. The increase should be greater than 3% of the 2023 results (28%) and will be measured as of December 31, 2024.	• Solicitated input from members through evaluation and screening. • Tailored communication to individual member needs. • Provided discharge summaries for transitioning patients. • Enhanced communication between PCPs and BHPs. • Advocated for integrated care, and utilized standardized documentation, and integrated EMR systems.

Plan Vital			
QS Goal	**PIP Topic**	**PIP Aim**	**PIP Interventions**
Triple-S			
Goal 1: Improve Health Outcomes for Enrollees	Improve Kidney Health Evaluation	Increase KED Measure result by 2.5% by the end of Measurement Year 2023 and an additional 2.5% by the end of measurement year 2024 for the HEDIS eligible population. Increase the percentage of adults with CKD (ages 18–85) with a completed HRA, Renal Assessment and Nutritional Assessment in Care Management. Increase the percentage of adults of enrollees with CKD 3,4, and 5 to have at least two annual visits to the nephrologist. Orient 10% of the enrollees on the “Mas Allá de tus Riñones " program.	In process.
Goal 2: Improve Preventative Care Screening, Access to Care and Utilization of Health Services	Increase Screening for Depression, Anxiety, SUD Screening	Increase screening for depression, for all covered populations using the nationally recognized screening tool PHQ-9, in need of improving MH outcomes. Increase screening for depression in Primary Care Groups in collaboration between a primary care provider, case manager and a MH specialist collocated.	In process.
Goal 1: Improve Health Outcomes for Enrollees	Improve Outcomes for Enrollees with Diabetes	Improvement in the Triple-S, Dental Visit benchmark percentage of Well Child Visits for the entire pediatric population in the 5- to 7-year-old category. Reach 50% of the total pediatric population aged 5–7 years included in the study. Recruit 30% of the total selected population that has not attended the dentist for their annual check-up. 100% completion of Pediatric HRA to eligible members.	• Evaluated database monthly to identify affiliates that qualify to participate in the program. • Conducted phone calls to affiliates to invite them to participate in the program and check the hours availability to attend the program. • Promoted the program in the PMGs and social networks.

Plan Vital			
QS Goal	**PIP Topic**	**PIP Aim**	**PIP Interventions**
			• Developed an educational campaign about the importance of the re-certification process to comply with the requirements to maintain health insurance. • Completed call blast to the target population of this program about the importance of testing A1C and keeping it under control. • Sent educational material to all affiliates about the A1C test and keep it under control. • Developed weekly face-to-face educational interventions and offered pre- and post-test. • Held two screening clinics to measure blood glucose levels. One will be conducted at the beginning of the program and one at the end of the program.
Goal 2: Improve Preventative Care Screening, Access to Care and Utilization of Health Services	Improve EPSDT Screening Rates	Improvement in the Triple-S, Dental Visit benchmark percentage of Well Child Visits for the entire pediatric population in the 5- to 7-year-old category. Reach 50% of the total pediatric population aged 5–7 years included in the study. To recruit 30% of the total selected population that has not attended the dentist for their annual check-up. 100% completion of Pediatric HRA to eligible members.	• Encouraged and assisted parents with scheduling dental visits. • Call blaster initiative for the entire EPSDT population (5–7 years) where parents are oriented about the importance of dental health visit. • Strengthened provider education on EPSDT preventive visits and dental care. • Identified barriers through outreach. • On-going monitoring of the Dental Health PIP Dashboard, which

Plan Vital			
QS Goal	**PIP Topic**	**PIP Aim**	**PIP Interventions**
			incorporates the claims received and outreach performed.
Goal 1: Improve Health Outcomes for Enrollees	Increase Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health	Increase the number of case discussions between the PCP and BH providers during the year. The increase should be greater than 2% of the 2023 results and will be measured as of December 31, 2024.	• Met with the PMGs and established different strategies to impact case discussion. • Facilitated re-orientation of PCPs, sharing PCP contact lists to co-located, establishment of case discussion meetings within co-located and PMG clinical staff. • Developed educational flyer to reinforce a multidisciplinary approach to case discussion.

Directed Payments

As of June 2024, ASES has six CMS-approved directed payments that support the advancement of its goals and objectives to improve health outcomes for enrollees, improve preventative care screening, access to care and utilization of health services and improve enrollee satisfaction with provided services and primary care experience. Some of the payments are to comply with federal law, for example the Consolidated Appropriations Act, but all have the overall goal of keeping needed providers on the island to ensure a network of providers is available to Plan Vital members. Listed below are the Plan Vital directed payments along with a summary of the objective for each.

- Minimum Fee Schedule for Urgent Care Centers: Ensuring access to urgent care and availability of urgent care clinic services will help to ensure emergency room use is limited to more emergent needs and help to ensure preventive care is provided.
- Minimum Fee Schedule for Dental Services: Ensuring access and availability of dental services will assist with increasing preventative dental services to prevent disease progression.
- Uniform increase for Short-term Acute Hospitals (STAC): Improve access to needed hospital care with appropriate follow-up for prevention of unnecessary admissions and unplanned 30 day readmissions.
- Minimum Fee Schedule for capitated Primary Care Providers (PCP): Maintain and improve access to primary care services.

- Minimum Fee Schedule for Specialists and Sub-specialists: Improve the number of initiatives to improve the health of enrollees with chronic conditions as well as improve enrollee satisfaction.
- Minimum Fee Schedule for All other Physicians and Laboratory Services: Preserve access to needed providers and allow for enrollee access to preventive services.

Physician Incentive Based Program

The physician incentive based program objective is to provide incentives based on physician performance where services promote the use of medical standards that support quality improvement, reduce adverse effects in enrollee care, advance quality initiatives supported by CMS and are not geared toward, and do not have the likely effect of, reducing or limiting services that an enrollee needs or may need. The MCOs will develop a physician incentive program in accordance with the Plan Vital Model Contract.

Special Coverage

ASES recognizes the importance for identifying enrollees with special conditions to proactively fast track required provider specialty services and ensure coordination of care for treatment. The Special Coverage Benefit initiative is in place to improve quality of care and access to required services for identified enrollees. 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 SHCN caused by serious illness. SHCN are defined as any physical, developmental, mental, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The MCOs are required to develop a system to screen enrollees for Special Coverage and register those that qualify. Registration for Special Coverage is based on intensive medical needs occasioned by serious illness. The plan must be submitted and approved by ASES. The list of conditions considered in Special Coverage listed below in Table 4 and outlined in the Plan Vital Model Contract.

Table 4: Conditions Considered in Special Coverage

Special Coverage Conditions			
Oculocutaneous Albinism, Hermansky-Pudlak Syndrome	Cystic Fibrosis	Leprosy	Phenylketonuria — Adult
Chédiak–Higashi Syndrome	Congestive Heart Failure Class III and Class IV	Systemic Lupus Erythematosus	Post-Transplant
Aplastic Anemia	Cleft Palate and Cleft Lip	Multiple Sclerosis	Chronic Renal Disease Level 3, 4, and 5

Special Coverage Conditions			
Rheumatoid Arthritis	Chronic Hepatitis C	Amyotrophic Lateral Sclerosis	Skin Cancer: Invasive Melanoma or Squamous Cells with Evidence of Metastasis and Carcinoma IN SITU
Autism	Hemophilia	Obstetric	Scleroderma
Evaluation for Cancer Diagnosis	HIV/AIDS	Primary Ciliary Dyskinesis	Children with Special Needs
Cancer	Inflammatory Bowel Disease	Pulmonary Hypertension	Tuberculosis
Other			

Most conditions are identified using ICD-10 identification. Exceptions to this are:

- **Evaluation for Cancer Diagnosis:** Identified by the MCO as instructed by ASES within the Policy for the Management of Patients Under Evaluation for Cancer Diagnosis. The purpose of this addition to special coverage is to expeditiously allow enrollees access to specialty care.
- **Children with Special Needs:** Special conditions of children, including specific prescribed conditions communicated via a normative letter.
- **Other:** Enrollees registered for special conditions that do not meet any of the listed conditions. Providers may request special coverage based on individualized enrollee presentation.

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, with the enrollee's participation, and in consultation with any specialists caring for the enrollee. MCOs require, in its Provider Contracts with primary care providers, that Special Coverage treatment plans be submitted to the MCO for review and approval in a timely manner. The Special Coverage Registry Report is used by ASES to oversee the program. This report quantifies the number of enrollees where the Contractor received registration request, the determinations for special coverage by diagnosis and decision turnaround time.

Cultural Competency

ASES requires that all MCOs have a Cultural Competency Plan in place to 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. The 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.

Practice Guidelines

In accordance with 42 CFR § 438.236 and the Plan Vital MCO Model Contract, the MCOs must include professionally developed practice guidelines based on scientific and reliable clinical evidence or a consensus of providers in the particular field. Practice guidelines must address the full range of health care needs of the populations served by the MCO and be applicable to providers for the delivery of certain services. Practice guidelines 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. Last, practice guidelines shall be disseminated to all affected providers, and upon request, to enrollees and potential enrollees.

Transition of Care

The ASES Transition of Care (TOC) policy is in place to ensure a seamless transition that is safe, timely, and orderly, and that will maintain effective coordination between responsible entities. The TOC policy is available on the ASES website: ASES Regulatory Reports (https://site-modules-master-d9ab073bd1970c34a98.webflow.io/informes-regulatorios?tab=InformesCongreso#Informes), and provides direction to maintain continuity of care for enrollees especially during transitions between health plans or health systems as it is critical to improving enrollees' quality of care and quality of life and their outcomes. MCOs and MAOs are to develop written policies and procedures to be submitted to ASES and updated annually which includes, at a minimum, the requirements in 42 CFR § 438.62(b)(1) and 42 CFR § 438.208(b)(2)(ii) and include the health information transfer process. The MCO/MAO TOC policy will describe all types of TOC that are relative to the contracts, benefits, and services enrollees are receiving, including:

- Existing enrollees transitioning from one Contractor to another Contractor.
- Existing enrollees transitioning from one provider to another provider.
- Enrollees moving from one setting or level of care to another.
- Law enforcement involved enrollees.
- Enrollees in foster care/or Virtual Region under protection of ADFAN (Administración de Familias y Niños).
- Veterans enrollees.
- New or existing pregnant enrollees.

The MCO/MAO TOC policy shall describe procedures for facilitating coordination of enrollee's services to include the following:

- Between settings of care, including appropriate discharge planning for short term and long term hospital and institutional stays.
- Services provided by other Contractors.
- Services the enrollee receives from community and social support providers.

Section 4
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 MCO and MAO report submission for other reporting areas as outlined within the Model Contracts.

To facilitate monitoring, oversight and contractual compliance, ASES has implemented the developed the Enterprise Systems (ES) platform. Reports submitted to the ES by the MCOs and MAOs allows for aggregate Medicaid program data, reporting from claims, MCO required reporting, Adult and Child Core Measure Sets, and EPSDT reporting to provide the ASES team with an array of program oversight and program integrity information within one location. The Comprehensive Oversight and Monitoring Program (COMP) that is housed within ES 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/MAO operational reviews, and allows ASES to establish and monitor corrective actions when required.

Within ES is an interactive tool, Utilization Anomaly Management (UAM) that allows ASES to document and communicate via messaging from the UAM to the MCOs/MAOs on report variance, data validation inquiries or other findings. The UAM records correspondence to and from the MCOs/MAOs and provides turn around tracking.

The ASES oversight program for GHP has been designed to use a top-down approach structured by identifying high-level metrics to measure MCO/MAO performance and comparing those metrics to benchmarks, either over time, against peer submissions, or to expectations. This comparison is done by consistent review of routine reporting and validated by MCO/MAO operational reviews subsequently enabling ASES to identify key targeted interventions as needed to maintain operational efficiency and contractual compliance.

Monitoring Programs

Plan Vital Quality Oversight

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

As described in Section 2, the HCIP provides guidance for the improvement interventions through the following three initiatives:

- Healthy People Initiative.
- Chronic Conditions Initiative.
- Emergency Room High Utilizers Initiative.

High Utilizers Program: Pursuant to the Plan Vital Model 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:

- Demographic data.
- Utilization data from the population.
- 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.
- Hospital data from the hospitals using the client contracting relationship with them.
- Authorization data from fast-track process for authorizations within MCOs.

Platino Quality Oversight

As noted previously, this updated version of the QS includes the strategy for oversight of Platino programming. Platino MAOs have been contracted to manage dually eligible members in Puerto Rico and have been in place since 2006. The Medicaid covered services for Platino members are limited to wrap around services that complement MA benefits and is seamless to the enrollee.

To address challenges with oversight, reporting and duplication, ASES with require submission of MA requirements that include the Platino Medicaid wrap around services:

- PIPs: Platino MAOs are not required to develop and submit PIPs. ASES will request and review the Medicare Chronic Care Improvement Program (CCIP) annual reports, as per 42 CFR 422.152(a)(2) and (c), MAOs are required to conduct Chronic Care Improvement Program (CCIP) initiatives. This will streamline oversite and decrease addition burden for the MAOs.
- PMs; Similarly, the Platino MAOs do not have PMs required specifically for Medicaid wrap around services. ASES will require the Platino MAOs to submit the Medicare audited HEDIS reports and review the performance.

Since the inception of Plan Vital, ASES has maintained separate contracts to provide medical and pharmaceutical services to its managed care members. The benefits ASES has realized with separating the pharmacy benefit from the MCO's contracts include additional transparency into the management of the pharmacy benefit, and more flexibility and direct control over pharmacy reimbursement.

Pharmacy Benefit Manager

When Plan Vital was implemented, ASES contracted with a PBM and a Pharmacy Benefit Administrator (PBA) to provide pharmacy benefit services to Plan Vital members. The rationale for contracting with two vendors was to separate and delineate between clinical and financial services. The PBM was responsible for the pharmacy network, benefit plan design, claims adjudication, formulary, and UM. The PBA was responsible for maintaining the

maximum allowable cost drug list, specialty drug pricing, drug manufacturer rebates, and financial reporting.

Selected Performance Measures

Plan Vital

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 (CY). ASES collects and reviews HEDIS measure reporting from the MCOs as well as a selection of CMS Adult and Child Core Measure Sets. MCOs are required to report the full CMS Adult and Child Core Sets. The results of these measures are available on the ASES website through MCPAR reporting, quality strategy evaluations and EQRO reports: ASES Regulatory Reports (https://site-modules-master-d9ab073bd1970c34a98.webflow.io/informes-regulatorios?tab=InformesCongreso#Informes).

Platino

For review of Platino PMs, ASES will request and review the HEDIS measures that CMS requires for Medicare Advantage plans. This approach allows ASES to evaluate overall performance for Platino enrollees in a manner that is enrollee centric, aligning both Medicare and Medicaid covered services. Below is the current list of CMS Medicare Advantage PMs.

Table 5: CMS Medicare Advantage PMs

Medicare Advantage PMs	
Advanced Care Planning (ACP)	Pharmacotherapy Management of COPD Exacerbation (PCE)
Antidepressant Medication Management (AMM)	Potentially Harmful Drug-Disease Interactions in Older Adults (DDE).
Care for Older Adults (COA)	Osteoporosis Management in Women Who Had a Fracture (OMW)
Colorectal Cancer Screening (COL)	Transitions of Care (TRC)
Controlling High Blood Pressure (CBP)	Use of High-Risk Medications in Older Adults (DAE)
Follow-Up After Hospitalization for Mental Illness (FUH)	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	

Compliance

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 QS. This includes the review of quality outcomes, timeliness of, and access to, the services covered under the managed care programs and validation of performance measures and PIP projects. To facilitate this process, the MCOs and MAOs supplies data, including but not limited to, claims data and medical records, to the EQRO. The CMS EQRO protocols includes the following:

- **Protocol 1 Validation of PIPs** as required under 42 CFR 438.340(b)(3)(ii): The Plan Vital MCOs shall conduct PIPs in accordance with ASES and, as applicable, federal protocols. The requirements for PIPs are specific to Plan Vital.
- **Protocol 2 Validation of PMs:** The PM Validation process assesses the accuracy of PMs reported by the MCO in accordance with 42 CFR § 438.358(b)(ii) and to determine the extent to which the MCO follows state specifications and reporting requirements. PM Validation refers to the EQRO's overall confidence that the PM calculation adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis, and produced accurate HEDIS rates.
- **Information System Capabilities Assessment (ISCA):** CMS regulations require that each MCO undergo an ISCA to enhance the review of the PMs and the Network Adequacy Validation. The focus of the review is on components of MCO information systems (IS) that contribute to claims receipt and processing, data integrity, PM production, and network reporting. This is to ensure that the system can collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system or other methods. The system must be able to ensure that data received from providers are accurate and complete, verify the timeliness of reported data, screen the data for consistency, and collect service information in standardized formats to the extent feasible and appropriate.
- **Protocol 3 Review of compliance with Medicaid and CHIP Managed Care Regulations:** The compliance review requires demonstration of the MCO's and MAO's compliance with federal regulations and state standards: To complete the review of compliance with Medicaid managed care regulations, the EQRO uses the mandatory compliance validation protocol (Protocol 3) to determine the extent to which MCOs and MAOs comply with federal standards set forth in 42 CFR 438, part 56, 100, 114, Subparts, QAPI, state standards, and MCO/MAO contract requirements. Below is a crosswalk of the standards reviewed by the EQRO to 42 CFR 438, the Subpart D and QAPI Standards.
- **Protocol 4 Validation of Network Adequacy:** As set forth in 42 CFR 438.68, states are required to set quantitative network adequacy standards for MCPs that account for regional factors and the needs of the state's Medicaid and CHIP populations. The purpose of this protocol is to guide the EQRO in conducting the validation of network

adequacy during the preceding 12 months to comply with requirements set forth in 42 CFR 438.68. This includes validating data to determine whether the network standards, as defined by the state, were met.

All protocols are provided to CMS in the EQRO technical report. This includes 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 QS. 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 plans to utilize the non-duplication option with their EQRO for Platino PIPS, PMs, and Network Adequacy. Platino MAOs will report annual HEDIS audited Medicare rates. The EQRO will provide an overview of Platino performance based on these reports and include the indication of PMs that were at or above the National Average for Medicare.

Table 6: Protocol 3 EQRO Standards

Standard Reviewed by the EQRO	Subpart D and QAPI Standard
Enrollee Rights and Protections	§438.56 Disenrollment Requirements and Limitations
	§438.100 Enrollee Rights Requirements
Access and Availability	§438.206 Availability of Services
	§438.207 Assurances of Adequate Capacity of Services
Care Management	§438.208 Coordination and Continuity of Care
	§438.224 Confidentiality
Utilization Management	§438.210 Coverage and Authorization of Services
	§438.114 Emergency and Post-stabilization Services
	§438.236 Practice Guidelines
Provider Network	§438.214 Provider Selection
	§438.230 Sub-contractual Relationships and Delegation
Grievance and Appeals	§438.228 Grievance and Appeal Systems
Quality Improvement and Assessment	§438.242 Health Information Systems
	§438.330 QAPI

Puerto Rico Network Adequacy Standards

Plan Vital Network Adequacy Standards

Contract provisions in Article 9 of the contract are established to incorporate specific standards in Plan Vital 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 on-site 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, as outlined in 42 CFR 438.358(b)(1)(iv). The following table provides the Plan Vital Network Standards.

Table 7: Provider-to-Enrollee Standards

Provider-to-Enrollee Standards
One Adult PCP and one Pediatric PCP per 1,700 enrollees (excluding Gynecologists).
One Gynecologist (selected as the enrollee's PCP, if the enrollee is female and 12 years of age or older) per 2,800 enrollees (1:2,800).
One Hospital per 50,000 enrollees (1:50,000).

Table 8: Provider per Municipality Standards

Provider per Municipality Standards
Two Adult PCPs and one Pediatric PCP in each municipality.
One Psychiatrist, Psychologist, Licensed Clinical Social Worker, or other Licensed BH Provider in each municipality.
Include available emergency stabilization units and psychiatric partial hospitalization programs to meet the needs of enrollees' island wide.

Table 9: Required Network Providers

Required Network Providers
The Contractor's provider network must have at least one Federally Qualified Health Center.
Government Healthcare Facilities required as outlined below: • Hospital Universitario Ramón Ruiz Arnau (HURRA) • Hospital Universitario de Adultos • Hospital Federico Trilla • Hospital Pediátrico Universitario • Centro Cardiovascular de PR y del Caribe • Administración de Servicios Médicos de PR (ASEM) • Comprehensive Cancer Center of Puerto Rico (Centro Comprensivo de Cancer) • Práctica Intramural del Recinto de Ciencias Médicas of the University of Puerto Rico operating at any hospital facility • Hospital Municipio de San Juan
Psychiatric hospitals required as outlined below: • Hospital Dr. Ramón Fernández Marina, San Juan • Hospital San Juan Capestrano • Hospital Metropolitano Psiquiátrico, Cabo Rojo • Hospital Panamericano, Cidra • Metro Pavía, Hato Rey • San Jorge Children and Women's, San Juan • Hospital Menonita CIMA, Aibonito • Hospital Metropolitano de la Montaña, Utuado • Hospital Pavía Yauco, Tito Mattei • Hospital Panamericano San Juan (Auxilio Mutuo) • Hospital Univ. Dr. Federico Trilla, Carolina • Hospital San Lucas, Ponce

Table 10: Time and Distance Standards

Time and Distance Standards (driving distance)
Enrollees living in Urban Areas and Non-Urban Areas must have a choice of at least two Adult and two Pediatric PCPs within 15 miles/30 minutes.
For female enrollees ages 12 and older living in Urban Areas and Non-Urban Areas must have a choice of at least two OB/GYN Providers within 15 miles/30 minutes.
Enrollees living in Urban Areas must have one Hospital within 30 miles/60 minutes. Enrollees living in Non-Urban Areas must have one Hospital within 45 miles/90 minutes.

Time and Distance Standards (driving distance)
Enrollees living in Urban Areas of Puerto Rico must have one ER within 20 miles/30 minutes. Enrollees living in Non-Urban Areas of Puerto Rico must have one ER within 20 miles/30 minutes.
Enrollees living in Urban Areas and Non-Urban Areas must have one Psychologist, one Psychiatrist and one Social Worker and/or Licensed Professional Counselor within 15 miles/30 minutes.
Enrollees living in Urban Areas must have one detoxification and rehabilitation Provider within 304 miles/60 minutes. Enrollees living in Non-Urban Areas must have one detoxification and rehabilitation Provider within 45 miles/90 minutes. Enrollees living in Urban Areas must have one Intensive Outpatient or Partial Hospitalization Provider within 30 miles/60 minutes. Enrollees living in Non-Urban Areas must have one Intensive Outpatient or Partial Hospitalization Provider within 45 miles/90 minutes. Enrollees living in Urban Areas must have at least one addiction medicine/withdrawal management provider within 30 miles/60 minutes. Enrollees living in Non-Urban Areas must have at least one addiction medicine/withdrawal management provider within 45 miles/90 minutes.
Providers classified as Adult High Volume Specialty Care Providers for purposes of Time and Distances standards are the following: Cardiology, Endocrinology, Oncology, Nephrology, and Pulmonology. Enrollees living in Urban Areas must have one of each type of Adult High Volume Specialty Care Provider within 30 miles/60 minutes. Enrollees living in Non-Urban Areas must have one of each type of Adult High Volume Specialist within 45 miles/90 minutes.
Providers classified as Pediatric High Volume Specialty Care Providers for purposes of Time and Distance standards are the following: Cardiology, Endocrinology, Oncology, Pulmonology, and Speech, Language, and Hearing. Enrollees living in Urban Areas must have one of each type of Pediatric High Volume Specialty Care Provider within 30 miles/60 minutes. Enrollees living in Non-Urban Areas must have one of each type of Pediatric High Volume Specialty Provider within 45 miles/90 minutes.
Enrollees living in Urban Areas must have one Dental Provider within 30 miles/60 minutes.
Enrollees living in Non-Urban Areas must have one Dental Provider within 45 miles/90 minutes.

Platino Network Adequacy Standards

The Platino Medicaid wrap around MAOs do not have specific Network Adequacy requirements in their contract today. Platino MAOs will submit their annual Platino Medicare Network Analysis of the CMS specific time and distance standards. ASES is evaluating MAO compliance with § 422 requirements and will continue to monitor any additional wrap around services added to the contract in the future and will set Platino Medicaid-only network adequacy standards as appropriate.

Table 6 outlines the required CMS Medicare Network standards provider types that the Platino MAOs will be required to address in their annual Network Analysis referenced above.

Table 11: Required CMS Medicare Network Standard Provider Types

Required CMS Medicare Network Standard Provider Types			
Primary Care	Gastroenterology	Ophthalmology	Urology
Allergy	General Surgery	Orthopedic Surgery	Vascular Surgery
Cardiology	OB/GYN	Rehab Medicine	Cardiothoracic Surgery
Chiropractor	Infectious Diseases	Plastic Surgery	Critical Care Units
Clinical Psychology	LCSW	Podiatry	Surgical Services
Dermatology	Nephrology	Psychiatry	Diagnostic Radiology
Endocrinology	Neurosurgery	Pulmonology	Mammography
ENT	Oncology	Rheumatology	PT/OT/ST
Inpatient Psych	Outpatient Infusion	Outpatient BH (new in 2025)	Acute Inpatient Hospitals
Cardiac Surgery and Catheterization			

Pharmacy Oversight and Monitoring

Preferred Drug List

ASES maintains a single Preferred Drug List (PDL) to ensure consistent access to medications among Plan Vital members and to simplify prior authorization processes for prescribers and MCOs. ASES Pharmacy and Therapeutics (P&T) Committee, which is comprised of practicing physicians and pharmacists, meets every two months. The P&T Committee recommends which therapeutic classes to include on the PDL, preferred and

non-preferred status for the drugs, and corresponding clinical guidelines for each class. The P&T Committee recommends preferred or non-preferred status for drugs on the PDL based on their clinical effectiveness, safety, and outcomes. When drugs within a class are clinically equivalent, the P&T Committee considers the comparative cost-effectiveness of all drugs in the class. Drugs designated as non-preferred are available but require prior authorization. ASES and its PBM monitor adherence to the PDL through regular analysis of reported claims data.

Key Service Level Metrics

As part of its contract requirements, ASES monitors key service level metrics to ensure the PBM is providing excellent service to ASES, pharmacies, and MCOs. Performance metrics have been established and penalties are assessed if it is determined any given measure has not been met.

Pharmacy Call Center Abandonment Rate:

- Pharmacy call center must have an Abandoned Call Rate of less than or equal to 5% out of all incoming calls.

Pharmacy Call Center Average Speed to Answer:

- The Average Speed to Answer of the PBM's required toll-free Pharmacy Call Center telephone line shall be greater than the target rate of 80% in 30 seconds.

Claims Payment Accuracy:

- PBM shall process and finalize to a "Paid" or "Denied" status 95% of all Clean Claims within 30 Calendar Days of receipt.
- PBM shall process and finalize to a paid or denied status 100% of all Clean Claims within 50 Calendar Days of receipt.
- PBM shall ensure 90% of Unclean Claims must be resolved and processed with payment by the PBM, if applicable, not later than 90 Calendar Days from the date of initial receipt of the claim. This includes claims billed on paper or electronically. Of the 10% of total Unclean Claims that may remain outstanding after 90 Calendar Days, PBM shall ensure:
    - 9% of the Unclean Claims must be resolved and processed with payment by the Contractor, if applicable, not later than six Calendar Months from the date of initial receipt (including claims billed on paper and those billed electronically).

Claims Processing System Availability:

- PBM shall ensure cumulative system unavailability within the PBM's span of control shall not exceed one hour during any continuous five Calendar Day period for functions that affect Plan Vital enrollees and shall not exceed four hours during any continuous five Business Day period for functions that do not affect Plan Vital enrollees.

Quarterly PBM Clinical and Business Reviews

On a quarterly basis, ASES meets with its PBM's account and clinical teams to review clinical and financial results, identify trends, and develop initiatives to improve prescription drug utilization and outcomes. Detailed reporting is prepared by the PBM and discussed with ASES' clinical operations and executive leadership team. At these meetings, drug utilization review strategies are identified for specific therapeutic classes and plans are developed to carry out the review and evaluate results.

Measurement and Improvement Standards

The MCO/MAO contracts require ongoing programs for quality assessment and performance improvement of the services provided to enrollees as required in 42 CFR 438.236 and 42 CFR 438.242. Quality measurement and improvement standards include practice guidelines, preventive services, PH and BH integration and health information systems. Each of these standards is defined as follows:

Practice Guidelines: As discussed, 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 (DoH), 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.

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 Plan Vital 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 Plan Vital population. In addition, the MCOs will submit an annual CMS-416 report that measures the EPSDT screening and participation rates.

CM Program: This program is driven towards to CM services for enrollees who demonstrate the greatest need, including those who have chronic, 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 ER visit or an inpatient stay in accordance with the Plan Vital Model Contract. The system will advocate for and link enrollees to services as necessary across providers and settings.

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.

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.

Co-location and Reverse Co-location 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.

Health Information Systems: The ASES IS has undergone 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 Plan Vital program, including, but not limited to, data pertaining to providers, enrollees, claims, encounters, grievance and appeals, disenrollment HEDIS and other quality measures. MCOs' IS 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.

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 HIT that drives real-time patient-level clinical and the utilization of electronic health records (EHRs) for care delivery efficiency and reduction of redundancy. This health information strengthens clinical decision-making, promote appropriate healthcare, manage costs, and improve quality through efficient program administration to virtually integrate and coordinate healthcare 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 Plan Vital program.
- Develop infrastructure capacity, and establish business processes within the Medicaid Enterprise, to provide adequate oversight of the Plan Vital program.
- Increase credibility with GHP stakeholders and CMS. This tool can be accessed directly by CMS.

Section 5

Corrective Action Plans and Intermediate Sanctions

The goal of ASES is to work closely with its MCOs and MAOs 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/MAOs 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/MAOs agree that, in addition to the terms of Section 35.1.1 of the GHP Contract, ASES may impose intermediate sanctions against the MCO/MAO for any such default in accordance Article 19 of the GHP Contract.

ASES will request CAPs from the MCO/MAO in cases for which non-compliance or the MCO/MAO 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.

If the MCO/MAO fails to comply with any material provision under a CAP submitted to ASES pursuant to Section 19.2.2 of the Model Contract, ASES may impose a daily $5,000 civil money penalty, up to a maximum total of $100,000 or the applicable intermediate sanction for any or all behavior that resulted in the submission of the CAP pursuant to Section 19.2. ASES will provide written notice to the MCO/MAO. The MCO/MAO has the right within 15 Calendar Days following receipt of the notice of imposition of intermediate sanctions to seek administrative review in writing of ASES' determination and any such immediate sanctions, pursuant to Act 72 or under any other applicable law or regulation. This time period can be extended for an additional 15 Calendar Days if the Contractor submits a written request that includes a credible explanation of why it needs additional time, the request is receipted by ASES before the end of the initial period, and ASES has determined that the Contractor's conduct does not pose a threat to an enrollee's health or safety. Below are descriptions of documentation provided:

- Monetary sanction imposed of $15,000 under Article 17.3.1 of the Contract and $25,000 for Annex C-6 for a total sanction of $40,000 for a data breach that initially occurred prior to 2022 when remediation was completed.
- CAP issued due to a persistent increase in abandoned calls to the medical advice line that fell outside of contract standards.
- CAP issued due to untimely claims payment.
- Compliance letter issued instructing MCOs to contract with all hospitals that provide BH services where the contracting was not complete.
- Compliance letter issued due to concern that the minimum payment to providers had not been made following a Normative Letter requiring minimum payment.

Section 6
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 DoH led management for the COVID-19 2020-2023 pandemic. ASES coordinated and followed their instructions to implement the initiatives established by DoH and public policy regulation. Testing, medication, and treatments were provided to the Medicaid population to mitigate the pandemic. As of May 11, 2023, coverage was updated to guarantee continued coverage for the medications with the end of the public health emergency.
- As of the end of Q1 2024, Puerto Rico government leaders have declared an epidemic after a marked rise in the number of dengue cases identified on the island. The DoH's epidemiological surveillance of diseases has observed a 140% increase in dengue cases for Puerto Rico compared to the same period last year. Working with the CDC and the Puerto Rico Vector Control Unit, the Puerto Rico DoH is enacting a dengue fever prevention and control plan that includes eliminating and cleaning up areas with stagnant water that could serve as mosquito breeding sites, as well as urging the public to use mosquito repellents and wire mesh panels to keep mosquitoes out of their homes. In 2022, ASES had issued a Normative Letter providing guidance and coverage for dengue testing and vaccines.
- Eradication of Hepatitis C by 2030 within the island of Puerto Rico is a DoH goal. This initiative is a high priority for ASES. Since 2020, Hepatitis treatment has been covered through a non-risk model with the MCOs. ASES has a process in place to identify enrollees with Hepatitis C and connect them to treatment. ASES is in the early stages of developing a process to apply PMs for testing of enrollees and treatment obtained for those that test positive. This will align with overall provider and enrollee messaging on this important initiative.

Section 7
Conclusion and Opportunities

Conclusion

ASES is focused on driving healthcare improvements in the Quality Improvement Initiative Areas noted in this QS. These initiatives remain important as the environment within Puerto Rico demonstrates significant opportunities to continue to focus on the health of members with chronic conditions and ensuring healthy members have access to strong preventative care. Barriers identified throughout the QS include:

- Close to 50% of all Puerto Rican's are covered under Medicaid.
- The islands experience widespread poverty.
- There is significantly higher incidence of chronic illness: Approximately 55% of the Medicaid population has at least one chronic condition.

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 QS.

Opportunities

Behavioral Health: Persons with BH needs are vulnerable and may face additional challenges due to the trauma from recent natural disasters, poverty and subsequent social determinants of health (SDOH). Cultural perception of mental illness and substance misuse may also deter persons from seeking treatment when needed. Continued focus on improving identification of and access for behavioral health conditions is an area of focus for ASES.

Health Disparities: An area of opportunity is the identification of health inequities within Puerto Rico and implementation of initiatives. The percent distribution of Puerto Rico population by race (across all racial categories recognized by the U.S. Census Bureau) shows the following: 51.15% are White, 9.96% are Black or African American, 0.16% are American Indian and Alaska Native, 0.19% are Asian, 0.01% are Native Hawaiian and other Pacific Islander, 21.59% are some other race and 16.95% are multiracial. When considering ethnicity, 3.27 million (98.76% of the total population) is Hispanic or Latino (of any race), and

40,913 (1.24% of the total population) is Non-Hispanic.[3] ASES is in the process of identifying the most impactful measures to identify and intervene for health disparities within the island. Concurrent with this initiative, future enhancements will include the stratification of PMs such as identifying enrollees' outcomes by age, race and ethnicity, gender, and location (rural versus urban areas). This will provide an ability to review outcomes and identify interventions for populations improvement.

[3] Puerto Rico Population by Race & Ethnicity — Neilsberg: https://www.neilsberg.com/insights/puerto-rico-population-by-race/#:~:text=The%20percent%20distribution%20of%20Puerto%20Rico%20population%20by,are%20some%20other%20race%20and%2016.95%25%20are%20multiracial.