

PUERTO RICO QUALITY MANAGEMENT STRATEGY



GOVERNMENT OF PUERTO RICO

CONTENTS

- 1. Introduction 1
 - Overview 1
 - Historical Background 1
 - Membership 3
- 2. Quality Program 5
 - Quality Strategy Purpose, Goals and Objectives 5
 - Special Health Care Needs 9
 - Quality Management Strategy Feedback Process 10
- 3. Puerto Rico Standards 15
 - Provider Network Access Standards 15
 - Measurement and Improvement Standards 17
- 4. Conclusions and Opportunities 24
- Appendix A: QMS Crosswalk 25

1

INTRODUCTION

OVERVIEW

The Puerto Rico Medicaid Quality Management Strategy (QMS) provides the guidance to advance island-wide quality improvement through a focus on performance improvement (PI) by providing quality services that are patient-centered and aimed at increasing the use of preventive care and appropriate delivery of care in a timely manner. The QMS has been revised in accordance with the Code of Federal Regulation (CFR) at 42 CFR 438.340. This is the fourth revision of the Quality Strategy which was first developed in 2006. This document includes the elements of the QMS required by the Centers for Medicare & Medicaid Services (CMS), but also includes Puerto Rico specific quality goals and measures. The Government of Puerto Rico (“the Government” or “Puerto Rico”) has delegated the managed care system to the Puerto Rico Health Insurance Administration (PRHIA) (known in Spanish with its acronym as the Administración de Seguros de Salud (“ASES”) de Puerto Rico).

In order to demonstrate compliance with the CMS Quality Strategy requirements set forth in 42 CFR 438.340, Puerto Rico prepared an analysis that identifies each required element of the QMS and where it has been addressed in the QMS (Appendix A). Puerto Rico will use this analysis as one of our many tools in our toolkit to evaluate the effectiveness of the QMS on improving the performance of our managed care partners and improving the quality of care.

HISTORICAL BACKGROUND

ASES has the responsibility to implement, administer, and negotiate through contractual arrangements those healthcare services included in the Puerto Rico Government Health Plan (GHP), which is also known as Plan Vital (both terms are used interchangeably in this document). The contracting of such services will be through those managed care organizations (MCOs) authorized by Federal and Puerto Rico law that will provide risk management as required under Titles XIX and XXI of the Social Security Act, as well under provisions in 42 CFR Part 438 and State Law 72 of September 7, 1993, as amended. Through these MCOs, the GHP provides a health insurance system that furnishes access covered services to Puerto Rico’s Medicaid population.

The QMS is designed to provide the framework to advance the GHP’s focus on PI activities by: building a culture that is focused on outcomes, efficiently deploying resources, setting realistic and attainable goals, and providing a pathway of progressive discipline to hold managed care contractors responsible and accountable. Because GHP offers an integrated benefit package which includes physical health (PH) and behavioral health (BH) services, we have found each component plays a critical part in the development of the QMS.

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

In 2015, the GHP implemented a new service model with objectives to transform Puerto Rico's health system that promotes an integrated approach to PH and BH and improves access to quality primary and specialty care services. The GHP Colocation and Reverse Colocation integrated model provides a health care delivery framework to improve access to care in an integrated and holistic manner. The MCOs facilitated the placement of a psychologist or other type of BH Provider in each Primary Medical Group (PMG) setting. In the scenario of Reverse Colocation, PH services are available to Enrollees being treated in BH settings.

On November 1, 2018, ASES expanded the 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 select an MCO that best meets their needs and desires. The island-wide approach facilitates access around the island and allows the MCOs to establish a wide network of Providers. The enrollees who were previously assigned to the virtual region (foster children and domestic violence victims) continue to be assigned to one MCO. In addition, the MCOs are responsible for ensuring continued care and provider access for enrollees transitioning between MCOs in accordance with section 5.5 of the contract and 42 CFR 438.62.

ASES provides the rules and focus on the performance it wants to achieve in order to maximize the resources without limiting access, timeliness, and quality of health care and is committed to define and design improvement projects focused on clinical and non-clinical aspects and access to services, which may prevent future health conditions and promote health among the GHP Enrollees. Plan Vital includes the Health Care Improvement Program (HCIP), which consists of four initiatives subject to performance indicators and a retention fund on the MCOs specified in the HCIP Manual which is found at Attachment 19 of the Contract. The HCIP program replaces Disease Management and other less effective elements and holds the MCOs financially responsible for meeting prescribed outcome measures.

The four initiatives are as follows:

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

The QMS provides the oversight and guidance to assess the needs and areas of improving the access, timeliness, and quality of health care of our Enrollees through PI projects, performance measures (such as Health Care Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcomes Survey (HOS), HCIP, etc.), as well as monitoring of the contractual compliance standards. In addition, Puerto Rico has developed an enhanced Care Management (CM) Program that has been modified to improve the health outcomes of the Medicaid population and devote greater resources and interventions to the medically complex by identifying high-cost/high-need (HCHN) populations and to close any gaps between the enrollee’s health care and the responsibility and role of providers treating that enrollee.

MEMBERSHIP

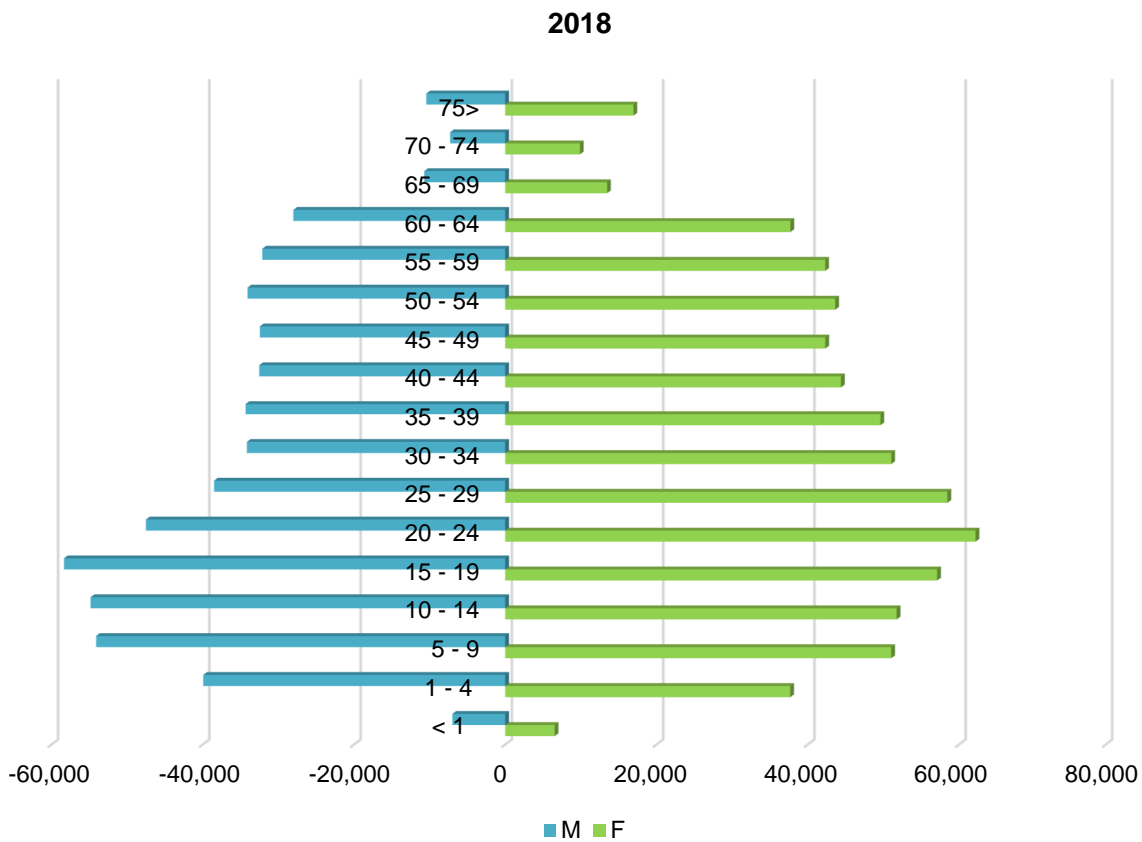
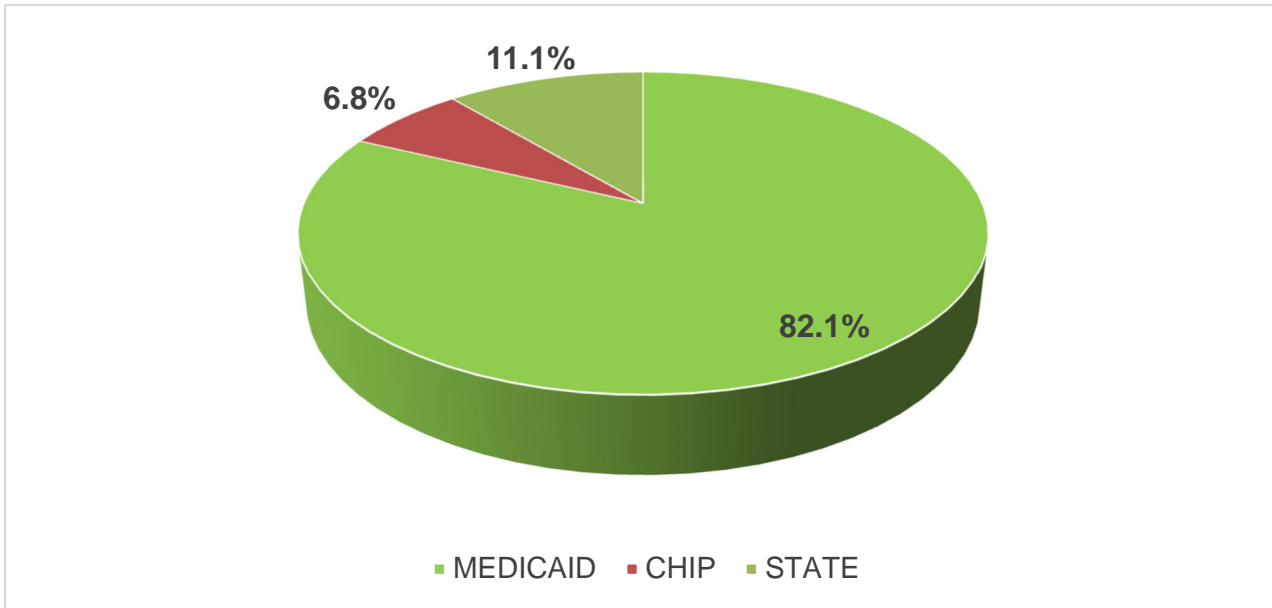
Puerto Rico has sole authority to determine eligibility for GHP, as provided in Federal law and Puerto Rico's State Plan, with respect to the Medicaid and CHIP eligibility groups. The island has a diverse geography covering 78 municipalities, which includes a mix of urban/semi-urban, suburban and rural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



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



The total population insured under GHP is **1,261,588 enrollees** as of June 2018. The following charts illustrate the insured population by eligible category, gender and age:



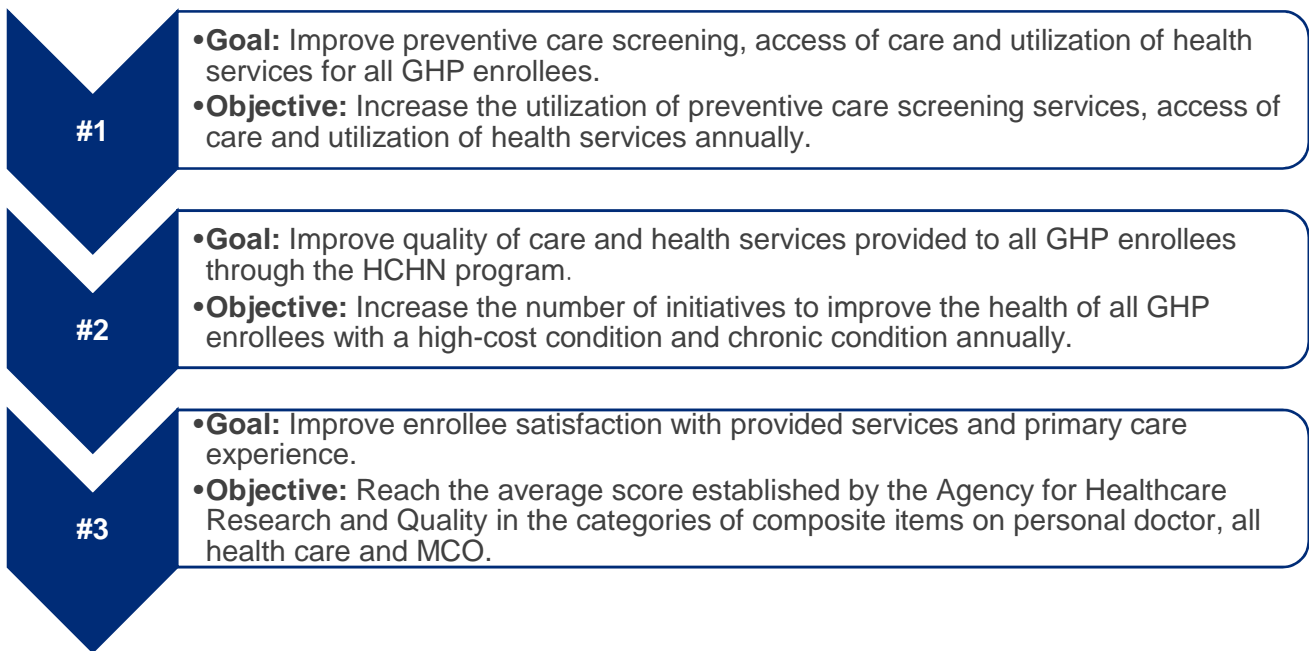
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QUALITY PROGRAM

QUALITY STRATEGY PURPOSE, GOALS AND OBJECTIVES

The QMS revision is based on Puerto Rico’s goal 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 through MCOs operating island-wide. The QMS provides a framework to communicate Puerto Rico’s vision of performance-driven objectives and monitoring strategies that address quality of care and timely access to services. It is a comprehensive approach that drives quality through assessment, initiatives, monitoring and outcome-based PI.

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



ASES recognizes that effective quality improvement must be methodical, ongoing and measurable. For the QMS, a mix of quantitative and qualitative measures have been identified to monitor clinical quality, access and utilization management (UM) for the program. Puerto Rico prefers to use nationally recognized measure sets whenever possible, including the National Committee for Quality Assurance (NCQA) HEDIS and the Medicaid Adult and Child Core Measurement Sets. Several tools have been developed to facilitate the implementation of the QMS. The HCIP is one of the tools developed by ASES to reach this goal. The HCIP Manual ties financial incentives for MCOs to improve the quality of the program. ASES created quality measures and scored quality measures for the MCOs to track and report quarterly; these measures are listed below. The MCOs must

develop initiatives to improve the health of the population for each scored measure for the health conditions identified in the HCIP. A second tool used is the reporting and review of annual HEDIS measures. In addition to the HCIP and HEDIS performance measures, the MCOs will submit enrollee and provider satisfaction survey data and analysis at least annually using CAHPS and the Experience of Care and Health Outcomes (ECHO) survey instruments.

MEETING GOALS AND OBJECTIVES

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

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

1. **Healthy People Initiative:** The Healthy People Initiative focuses on preventive screening for all enrollees, including populations identified with high-cost or chronic conditions. The scored measure point distribution for the Healthy People Initiative is a total of 10 points.
2. **High Cost Conditions Initiative:** The High Cost Conditions Initiative focuses on those enrollees with a high-cost condition that may be part of the HCHN Program specified in Section 7.8.3 of the Contract. The MCOs are to propose and demonstrate cost saving initiatives, programs, and value-based payment models for provider reimbursement to address HCHN enrollees. The scored measure point distribution for the High Cost Conditions Initiative is a total of 11 points.
3. **Chronic Conditions Initiative:** The Chronic Conditions Initiative focuses on those enrollees with a chronic condition. Chronic conditions are often complex, generally long-term and persistent, and can lead to a gradual deterioration of health. The MCOs shall include in the quality plan, the use of best practices for care to improve the health of those with a chronic condition.
4. **Emergency Room High Utilizers Initiative:** The Emergency Room High Utilizers Initiative is designed to identify high users of emergency services (including BH) for non-emergency situations and to allow for early interventions to ensure appropriate utilization of services and

resources. The MCO will submit to ASES for approval, a work plan with detailed activities and interventions aimed at emergency room high utilizers.

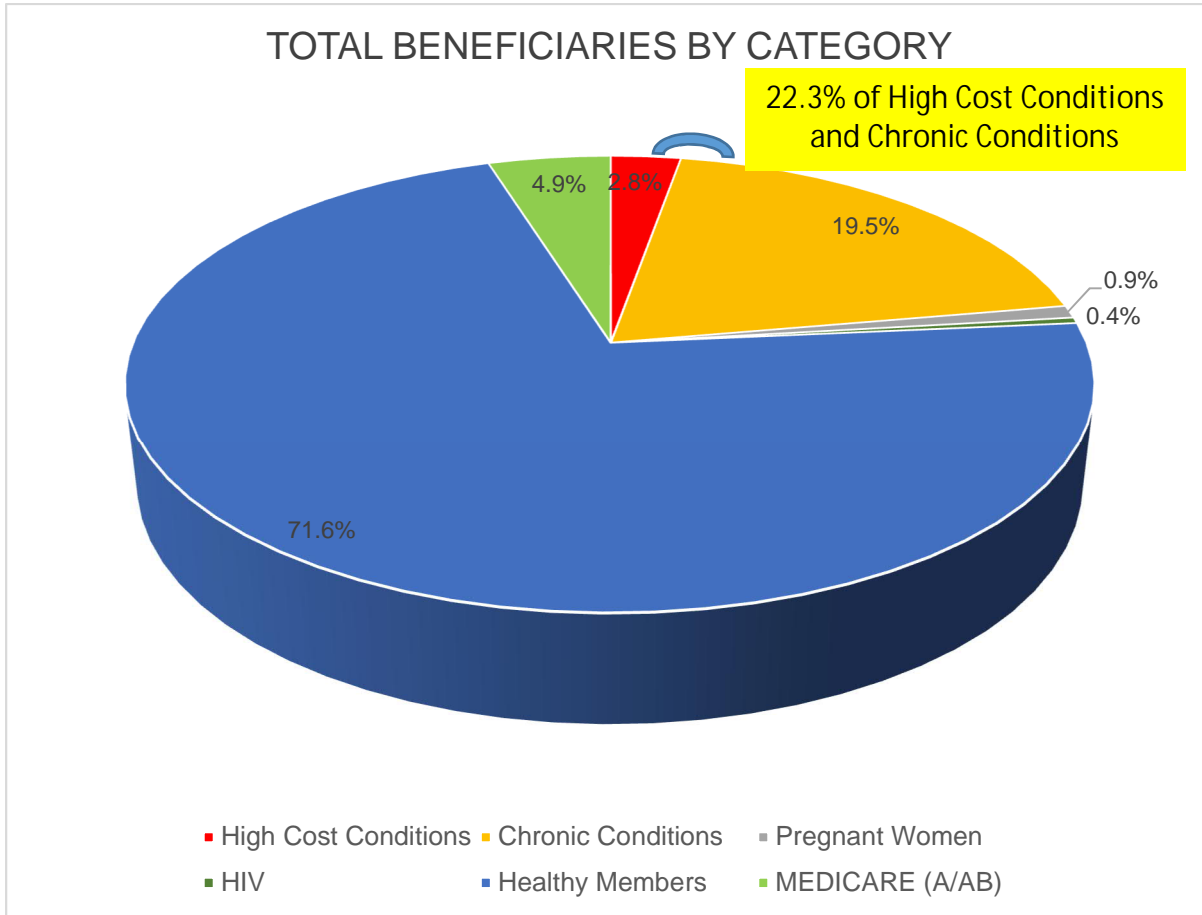
Additional strategies developed by ASES to achieve goals and objectives, and established in the quality strategies are:

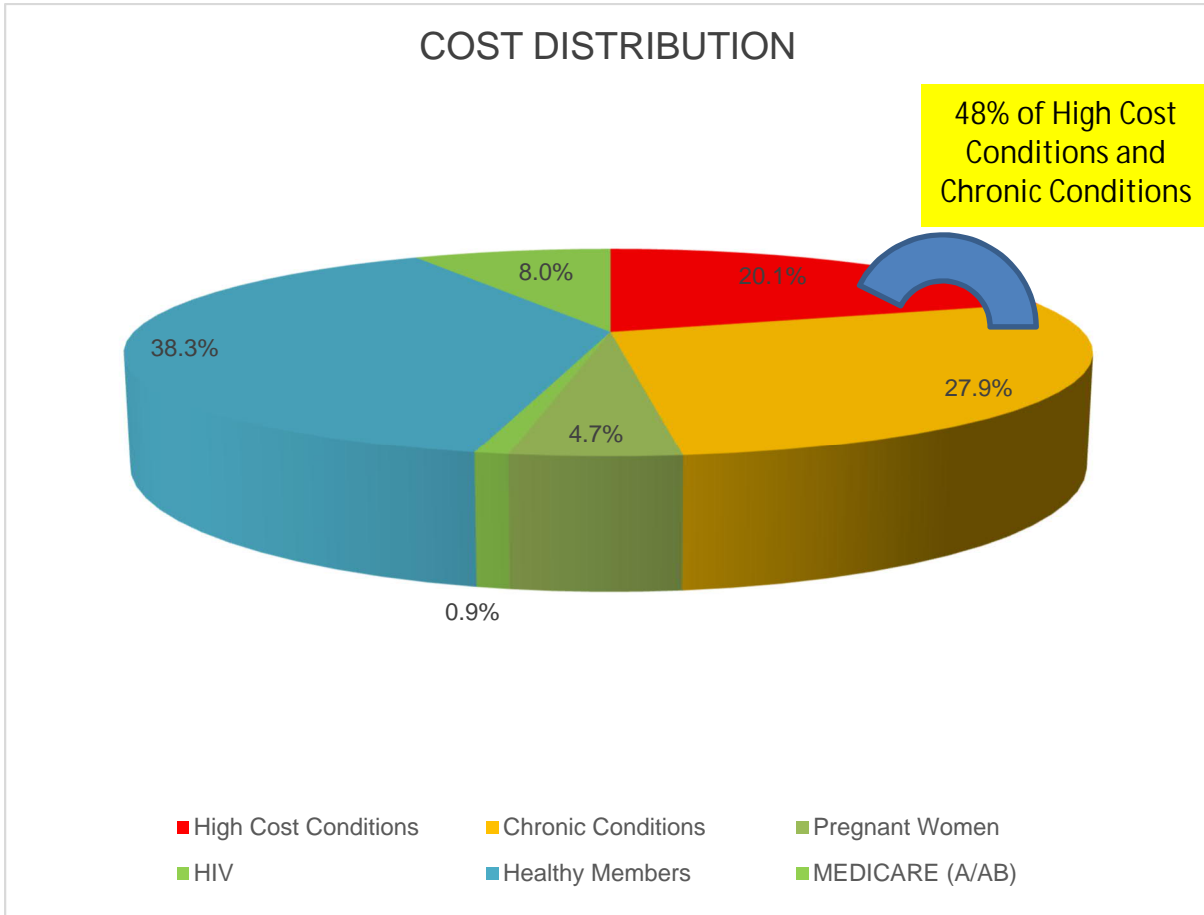
- Developing and maintaining collaborative agreements among public agency stakeholders to improve health education and health outcomes as well as manage vulnerable and at-risk enrollees.
- Improve health information technology (HIT) to ensure that information retrieval and reporting are timely, accurate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

PROGRAM POPULATIONS

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

Reviewing claims from 2017, 22.3% of the enrollees meet the definition as high-cost or chronic conditions accounting for 48.1% of the total health cost. The conditions identified within high-cost conditions include cancer, end stage renal disease, rheumatoid arthritis, diabetes, asthma, hypertension and chronic obstructive pulmonary disease as the chronic conditions. The current program allows for greater resources, efforts and interventions be devoted to the need and to implement integrated care programs for people with high-cost conditions, high-need and socioeconomic factors based on morbidity, use of services and HCHN.





SPECIAL HEALTH CARE NEEDS

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

MCOs monitor and routinely update a treatment plan for each enrollee who is registered for Special Coverage. The treatment plan shall be developed by the Enrollee's Primary Care Provider (PCP), with the enrollee's participation, and in consultation with any specialists caring for the enrollee. MCOs require, in its Provider Contracts with PCPs, that Special Coverage treatment plans be submitted to the MCO for review and approval in a timely manner. A list of conditions considered in Special Coverage is included in Appendix A.

High-Cost/High-Needs Enrollees

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

High-Utilizer Program

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

QUALITY MANAGEMENT STRATEGY FEEDBACK PROCESS

The QMS is designed to ensure that services provided to enrollees meet or exceed established standards for access to care, clinical quality of care and quality of service. In accordance with 42 CFR 438.340(c)(2), the QMS will be reviewed and updated no less than once every three years. ASES will achieve this ongoing review and evaluation through reporting, oversight and monitoring of the MCOs and through its External Quality Review Organization (EQRO). ASES will also submit a revised QMS at any point if there is a significant change as a result of the ongoing review and evaluation. A significant change will encompass major program changes (i.e., new/change in services, new/change in populations) or a change in any of the program goals. The public input process described in further detail below will be utilized for any resubmission of the QMS to CMS.

In accordance with 42 CFR 438.340(c)(1), GHP enrollees, the general public, and stakeholders will have the opportunity to provide input and recommendations regarding the content and direction of the QMS. The QMS is posted on the ASES website for a two-week period to receive public feedback via mail, email and telephonic feedback. A final QMS approved by CMS 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 QMS on an ongoing basis. This is achieved through the Advisory Board delegated to the MCOs in accordance with Section 12.1.8 of the Contract, as well as enrollee and provider satisfaction surveys, enrollee grievances and appeals, and public forums for the GHP program. ASES will incorporate recommendations from enrollees, the general public, MCOs, the EQRO and other stakeholders in setting new goals and revising the QMS as an ongoing process.

ASES has contractual requirements in place for ensuring MCOs' compliance with the structure and operational standards of 42 CFR 438, Subpart D. ASES evaluates the effectiveness of the QMS through ongoing monitoring efforts and oversight of the MCOs. CMS requires the QMS be reviewed and updated no less than once every three years per 42 CFR 438.340(c)(2). ASES will submit a revised QMS at any point there is a significant change as a result of ongoing review and evaluation.

A significant change will encompass major program changes (i.e., new services, new populations) or a change in any of the program goals. Public input is important to the process; participant feedback will be obtained through the MCO Advisory Committee, as well as member and provider satisfaction surveys and member grievances and appeals. This final draft of the QMS, as well as the evaluation of the effectiveness of the previous QMS is currently posted for a two-week period to receive public input for incorporation into the QMS.

3

STANDARDS, GUIDELINES AND DEFINITIONS

QUALITY AND APPROPRIATENESS OF CARE

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

- QAPI Program
- Puerto Rico-specific data collection and monitoring, and MCO reporting
- EQRO reports
- CMS 416 report
- HCIP

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

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

CULTURAL COMPETENCY

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

ASES SELECTED HEDIS MEASURES

ASES collects and reviews a substantial proportion of the CMS adult and child core performance measures. As part of the 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.

CLINICAL PRACTICE GUIDELINES

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

MEMBER SATISFACTION

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

MONITORING AND COMPLIANCE

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

EXTERNAL QUALITY REVIEW

To ensure the accuracy and validity of the data submitted and in compliance with 42 CFR 438.350 and 438.358, ASES contracts with an EQRO to conduct annual, independent reviews of the QMS. This includes the review of quality outcomes, timeliness of, and access to, the services covered under the GHP and validation of performance measures and PI projects. To facilitate this process, the MCOs supply data, including but not limited to claims data and medical records, to the EQRO. The EQRO's Scope of Work includes all CMS mandated EQRO protocols and includes the following:

1. **Performance Improvement Projects (PIPs)** as required under 42 CFR 438.340(b)(3)(ii). The MCOs shall conduct PIPs in accordance with ASES and, as applicable, Federal protocols. The PIPs will be developed, implemented and maintained following the protocols outlined in Section 12.3 of the contract. At a minimum, the topics of the PIPs are:
 - A. One clinical care project in the area of increasing fistula use for Enrollees at-risk for dialysis;
 - B. One clinical care project in the area of BH;

- C. One administrative project in the area of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening;
 - D. One administrative project in the area of reverse co-location and co-location of PH and BH and their integration; and
 - E. The Contractor shall conduct additional PIPs as specified by ASES during the Contract Term.
2. **Program Integrity** The evaluation in this area includes at a minimum the review of MCOs' policies and procedures, training programs, reporting and analysis; compliance with Annual Disclosure of Ownership (ADO) and financial interest provisions; and file review of program integrity cases.

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

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

The report also includes an assessment of the MCOs' strengths and weaknesses, as well as recommendations for improvements. ASES uses the information obtained from each of the Mandatory EQR activities, as well as the information presented in the EQR technical report, to make programmatic changes and modifications to the QMS. ASES monitors MCO performance against certain standards to potentially identify opportunities to use other survey results for evaluation in an effort to minimize duplication of activities.

4

PUERTO RICO STANDARDS

PROVIDER NETWORK ACCESS STANDARDS

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

FEDERAL REGULATION	DESCRIPTION	GHP CONTRACT REFERENCE
438.206	Availability of services	9.1.2
438.206(b)(1)	Maintains and monitors a network of appropriate Providers	9.3
438.206(b)(2)	Female Enrollees have direct access to a women's health specialist	9.3.1.10
438.206(b)(3)	Provides a second opinion from a qualified health care professional	11.7
438.206(b)(4)	Adequately and timely coverage of services not available in-network	9.3.1.8
438.206(b)(5)	Out-of-network Providers coordinate with the MCO with respect to payment	9.3.1.8
438.206(b)(6)	Credential all Providers as required by 42 CFR 438.214	9.2.3
438.206(c)(1)(i)	Providers meet state standards for timely access to care and services	9.1.5.3, 11.4.2
438.206(c)(1)(ii)	Network Providers offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or comparable to Medicaid fee-for-service	9.5.3.1
438.206(c)(1)(iii)	Services included in the contract are available 24 hours a day, 7 days a week	10.3.1.3.34
438.206(c)(1)	Mechanisms/monitoring to ensure compliance by Providers	9.3.3.5.1.2
438.206(c)(2)	Culturally competent services to all Enrollees	6.11

FEDERAL REGULATION	DESCRIPTION	GHP CONTRACT REFERENCE
438.207	Assurances of adequate capacity and services	9.1.13
438.207(a)	Assurances and documentation of capacity to serve expected enrollment	9.1.13.2
438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services	9.1.13.1.2
438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution	9.1.3.7
438.208	Coordination and continuity of care	7.8.2.3, 9.3.3, 9.3.1.5.1
438.208(b)(1)	Each Enrollee has an ongoing source of primary care appropriate to his or her needs	9.3.1.5
438.208(b)(2)	All services that the Enrollee receives are coordinated with the services the Enrollee receives from any other MCO/PIHP	5.5 (all services are under one MCO)
438.208(b)(3)	Share with other MCOs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services	9.5.2
438.208(b)(4)	Protect enrollee privacy when coordinating care	5.3.8.3
438.208(c)(1)	State mechanisms to identify persons with special health care needs	9.5.2
438.208(c)(2)	Mechanisms to assess enrollees with special health care needs by appropriate health care professionals	9.5.2
438.208(c)(3)	If applicable, treatment plans are developed by the enrollee's PCP with Enrollee participation, and in consultation with any specialists caring for the Enrollee; approved in a timely manner; and in accord with applicable state standards	9.5.2
438.208(c)(4)	Direct access to specialists for enrollees with special health care needs	9.5.2.2
438.210	Coverage and authorization of services	11.2.4.2, 11.4
438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service	9.1.2
438.210(a)(2)	Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid	9.1.2
438.210(a)(3)(i)	Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished	9.1.2

FEDERAL REGULATION	DESCRIPTION	GHP CONTRACT REFERENCE
438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	7.1.2
438.210(a)(3)(iii)	Each MCO may place appropriate limits on a service, such as medical necessity	7.2
438.210(a)(4)	Specify what constitutes “medically necessary services”	7.2
438.210(b)(1)	Each MCO and its subcontractors must have written policies and procedures for authorization of services	11.2.1
438.210(b)(2)	Each MCO must have mechanisms to ensure consistent application of review criteria for authorization decisions	11.2.1.1
438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate health care professional	11.2.1.9
438.210(c)	Each MCO must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested	14.4.1
438.210(d)	Provide for the authorization decisions and notices as set forth in 42 CFR 438.210(d)	11.2
438.210(e)	Compensation to individuals or entities that conduct UM activities does not provide incentives to deny, limit, or discontinue medically necessary services	11.2.4

MEASUREMENT AND IMPROVEMENT STANDARDS

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

1. **Clinical Practice Guidelines:** ASES requires that MCOs adopt clinical standards consistent with current standards of care, complying with recommendations of professional specialty groups or the guidelines of programs such as: Puerto Rico Department of Health, American Academy of Pediatrics, American Academy of Family Physicians, the United States Preventive Services Task Force, American Medical Association’s Guidelines for Adolescent and Preventive Services, Substance Abuse and Mental Health Services Administration, American Psychological Association, American Academy of Pediatrics, the American College of Obstetricians and Gynecologists and the American Diabetes Association.
2. **Preventive Services:** As part of the required improvement programs, ASES has established clinical standards/guidelines for which each MCO is required to ensure preventive services and screenings are an integral part of the GHP program. This allows for better UM mechanisms and

guaranteeing access to healthcare in a timely manner for the prevention of diseases and promoting health among the GHP population. In addition, the MCOs will submit an annual CMS-416 report that measures the EPSDT screening and participation rates.

3. **Care Management Program:** This program is driven towards to CM services for enrollees who demonstrate the greatest need, including those who have chronic, HCHN conditions and/or who require intensive assistance to ensure integration of PH and BH needs. The MCOs' CM systems emphasize prevention, continuity of care and coordination of care. The model of care developed by the MCOs shall include a plan to ensure that appropriate services are in place when transitioning from an emergency room visit or an inpatient stay in accordance with section 7.8.3.2 of the contract. The system will advocate for and link enrollees to services as necessary across providers and settings.
4. **Prenatal Care Program:** This program focuses on providing access to prenatal care services during the first trimester, preventing complications during and after pregnancy, and advancing the objective of lowering the incidence of low birth weight and premature deliveries. The primary attention within the program is on the promotion of healthy lifestyles and adequate pregnancy outcomes through educational workshops regarding prenatal care topics (importance of prenatal medical visits and post-partum care), breast-feeding, stages of childbirth, oral and mental health, family planning and newborn care, among others. In addition, the program engages in the proper access and provision of those screening test during the pregnancy.
5. **Provider Education Program:** The purpose of this program is to provide an ongoing educational activity on clinical and non-clinical topics. Puerto Rico's Medicaid Agency, through its Agent, requires that the MCO provide for providers, at least 20 continuing education hours (five per quarter) on an annual basis. Delivery of the Provider Education Curriculum and schedule to the ASES is necessary for approval prior to execution and implementation of such and in accordance with 10.2.2.1.
6. **Collocation and Reverse Collocation Model:** ASES has established the "integration model" to ensure that PH and BH services are closely interconnected, ensure optimal detection, prevention, and treatment of physical and mental illness. The MCOs will ensure that PH and BH services are fully integrated, to ensure optimal detection, prevention, and treatment of PH and BH illness. The MCOs (through contracted PCPs, PMGs and other Network Providers) will focus on ensuring that both PH and mental health services coordinated with a continuity of care plan (42 CFR 438.208(b)) with case managers as the gateways between the Enrollees and the primary care services.
7. **Health Information Systems:** The ASES Information System has under gone transformation for an Underwriting and Actuarial Database Implementation. The Med-Insight project was designed to transform data into knowledge, using Milliman, Inc. proprietary relational database tools to perform analysis and reporting with the capability to extract and provide multidimensional views of the data. The Milliman MedInsight® system offers a suite of products

designed to work together to provide a complete data reporting and analysis solution. With MedInsight®, ASES can perform the following functions:

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

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

A. Medicaid Management Information System (MMIS): Puerto Rico has initiated a project to improve the health of individuals, families and communities through the meaningful use of health information technology and health information to strengthen clinical decision-making, promote appropriate health care, manage costs, and improve quality through efficient program administration to virtually integrate and coordinate health care delivery for the enrollees in government-funded healthcare programs. The MMIS project goals include the following:

- Transform the Puerto Rico Medicaid Enterprise into an information-driven organization with access to information, down to the level of the point-of-care.
- Fully meet the present and future information needs of the GHP program.
- Develop infrastructure capacity, and establish business processes within the Medicaid Enterprise, to provide adequate oversight of the GHP program.
- Increase credibility with GHP stakeholders and CMS.

B. EHR Incentives

In accordance with the Federal Regulation Code under the 42 CFR 495, the American Recovery & Reinvestment Act of 2009 (ARRA) and the Health Information Technology for Economic and Clinical Health (HITECH Act) of 2009, the EHR Incentive Program has been renamed Puerto Rico Medicaid Program Interoperability Promotion (MPIPPR). The MPIPPR

is in place to continue the agency's focus on improving enrollee access to health information and reducing the time and cost required of providers to comply with program requirements.

The MPIPPR has two stages:

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

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

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

5

IMPROVEMENT AND INTERVENTIONS

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

1. **HCIP** provides guidance for the improvement interventions through the following four initiatives:
 - A. Healthy People Initiative
 - B. High Cost Conditions Initiative
 - C. Chronic Conditions Initiative
 - D. Emergency Room High Utilizers Initiative
2. **High Utilizers Program:** Pursuant to Section 7.14 and Attachment 25 of the contract, the MCOs shall collaborate with ASES to develop and implement a High Utilizers Program, including but not limited to, providing data related to PH and BH services such as:
 - A. Demographic data
 - B. Utilization data from the population
 - C. Real-time data from the hospitals to know every time that one of the patients in the program or patients identified as prospects for the program enters the hospital
 - D. Hospital data from the hospitals using the client contracting relationship with them
 - E. Authorization data from fast track process for authorizations within Plans
3. **Physician Incentive-Based Program:** This program objective is to provide incentives on cash towards the physician performance where services promote the use of medical standards that support quality improvement and reduce adverse effects in enrollee care, advance the quality initiatives supported by CMS and are not geared toward, and do not have the likely effect of, reducing or limiting services that enrollee need or may need. The MCOs will develop a physician incentive program in accordance with Section 10.7 of the Contract.

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.

7

CORRECTIVE ACTION PLANS AND INTERMEDIATE SANCTIONS

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

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

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

8

CONCLUSIONS AND OPPORTUNITIES

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

APPENDIX A

QMS CROSSWALK

NUMBER	FEDERAL REGULATION	DESCRIPTION	QMS PAGE REFERENCE
1	N/A	Include a brief history of the state’s Medicaid (and CHIP, if applicable) managed care programs.	1
2	N/A	Include an overview of the quality management structure that is in place at the state level.	1
3	N/A	Include a description of the goals and objectives of the state’s managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the state’s priorities and areas of concern for the populations covered by the MCO contracts.	5
4	438.340(b)(1)	State-defined network adequacy standards developed in accordance with 438.68 (e.g., time and distance Provider standards).	15
5	438.340(b)(1)	State-defined availability of services standards developed in accordance with 438.206(b)(1)-(7) (e.g., direct access to women’s health specialist; timely access standards for routine urgent and emergent services; 24/7 service availability; access and cultural competency; accessibility considerations).	15
6	438.340(b)(1)	State’s approach to adoption and dissemination of evidence-based CPGs in accordance with 438.236.	13
7	438.340(b)(5)	Description of the state’s transition of care policy required under 438.62(b)(3).	18,25
8	438.340(b)(9)	Mechanisms implemented by the state to comply with 438.208(c)(1) (relating to the identification of persons with special health care needs).	9
9	438.340(b)(10)	The information required under 438.360(c) (relating to non-duplication of EQR activities).	14

NUMBER	FEDERAL REGULATION	DESCRIPTION	QMS PAGE REFERENCE
10	438.340(b)(2)	Developing goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations served by MCOs.	5
11	438.340(b)(3)(i)	A description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO with which the state contracts, including but not limited to, the performance measures reported in accordance with 438.330(c). The state must identify which Quality Measures and performance outcomes the state will publish at least annually on the ASES website.	12
12	438.340(b)(3)(ii)	A description of the PIPs implemented in accordance with 438.330(d), including a description of any interventions the state proposes to improve access or timeliness of care for Enrollees.	13
13	438.340(b)(4)	Arrangements for annual, external independent reviews, in accordance with 438.350, of the quality outcomes and timeliness or, and access to, the services covered under each MCO.	13
14	438.340(b)(6)	The state’s plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status (as basis for Medicaid eligibility). States must identify this demographic information for each Enrollee and provide it to the MCO at time of enrollment.	7
15	438.340(b)(7)	Appropriate use of intermediate sanctions that, at a minimum, meet the requirements of 42 CFR part 438, subpart I.	23
16	438.340(c)(1)	Public Comment — obtaining input from the Advisory Board.	10
17	438.340(c)(1)(i)	Public Comment — process for broader stakeholder engagement and comment.	7, 10
18	438.340(c)(3)	Submitting the Quality Strategy to CMS.	10

NUMBER	FEDERAL REGULATION	DESCRIPTION	QMS PAGE REFERENCE
19	438.340(c)(2)	Review and update Quality Strategy no less than once every three years.	10
20	438.340(d)	Posting the Final CMS-Approved Quality Strategy to the ASES website.	10
21	438.340(c)(i)	Evaluation of Effectiveness of Previous Quality Strategy.	2, 10
22	438.340(b)(11)	The state’s definition of a “significant” change for purposes of revising the Quality Strategy and submitting to CMS.	10

**PUERTO RICO QUALITY MANAGEMENT STRATEGY
EVALUATION**



GOVERNEMENT OF PUERTO RICO

CONTENTS

1. INTRODUCTION AND PURPOSE.....	2
2. OBJECTIVES AND GOALS	3
3. GOAL #1: IMPROVED ACCESS TO PRIMARY AND PREVENTATIVE CARE SERVICES.....	5
4. GOAL #2: PHYSICAL AND BEHAVIORAL HEALTH INTEGRATION	7
5. GOAL #3: MEMBER’S EXPERIENCE AND SATISFACTION	9
6. PUBLIC/STAKEHOLDER COLLABORATION.....	11
7. CONCLUSION	12

1

INTRODUCTION AND PURPOSE

The Puerto Rico Quality Management Strategy (QMS) provides the guidance to advance island-wide quality improvement through a focus on performance improvement (PI) by providing quality services that are patient-centered and aimed at increasing the use of preventive care and appropriate delivery of care in a timely manner. The QMS has been revised in accordance with the Code of Federal Regulation (CFR) at 42 CFR 438.340. This is the fourth revision of the Quality Strategy which was first developed in 2006 and includes the elements of the QMS required by the Centers for Medicare & Medicaid Services (CMS), as well as Puerto Rico specific quality goals and measures. The Government of Puerto Rico (“the Government” or “Puerto Rico”) has delegated the managed care system to the Puerto Rico Health Insurance Administration (PRHIA) (known in Spanish with its acronym as the Administración de Seguros de Salud (“ASES”) de Puerto Rico). ASES has the responsibility to implement, administer, and negotiate through contractual arrangements those healthcare services included in the Puerto Rico Government Health Plan (GHP).

In order to demonstrate compliance with CMS’s quality strategy evaluation requirements set forth in 42 CFR 438.340, Puerto Rico has evaluated its previous QMS from 2015, to measure the effectiveness and to help shape health care delivery and policy for the program going forward. The newly drafted QMS, along with this quality strategy evaluation is posted publicly on the ASES website for review and comment. Updates to both documents will be made accordingly, dependent on the feedback that is provided. A final copy of both documents will then be submitted to CMS for approval.

2

OBJECTIVES AND GOALS

Puerto Rico strongly believes in working closely with its MCOs in a collaborative and proactive manner to improve the quality of care and services received under the GHP program and the nature of a continuous Quality Improvement (QI) program. The contracted MCOs, through several mechanisms, are routinely monitored by ASES to insurance contractual compliance and evaluation the health outcomes for the GHP population.

Specific data is captured to support the quality evaluation process. Data gathered by ASES during the quality survey process is compiled for evaluation and trending to identify areas for improvement. Upon completion, identified areas of improvement are compiled into reports and shared both internally and externally. Monitoring and survey results are compiled, trended, reviewed and disseminated consistent with protocols identified in the Puerto Rico quality improvement strategy. The information that is received and analyzed is used to provide continuing guidance for the overall quality strategy as a roadmap.

The specific goals and objectives that play a significant role in the development of Puerto Rico's quality strategy are outlined below:

1. Improve timely access to primary and preventive care services for all GHP Medicaid, Federal and State, and CHIP Enrollees.
2. Improve quality of care and services provided to all GHP Medicaid, Federal and State, and CHIP Enrollees through a physical and behavioral health integrated approach based on the Colocation and Reverse Colocation model.
3. Improve member's satisfaction with provided services and primary care experience. Rates are expected to reach the average score established by the Agency for Healthcare Research and Quality (AHRQ) in the composite items:

Consumer Assessment of Healthcare Providers and Systems (CAHPS):

- a. Rating of personal doctor
- b. Rating of all health care
- c. Rating of health plan

Experience of Care and Health Outcomes (ECHO) Survey:

- a. Getting treatment quickly
- b. How well clinicians communicate
- c. Getting treatment and information from the plan
- d. Perceived improvement
- e. Information about treatment options
- f. Overall rating of counseling and treatment
- g. Improve member's satisfaction with provided services and primary care experience.

3

GOAL #1: IMPROVED ACCESS TO PRIMARY AND PREVENTATIVE CARE SERVICES

Primary and preventative care services promote a healthy lifestyle through avoiding health problems or their early detection. The goal of improving access and maintaining consistent use of these services are crucial to all GHP enrollees. The Healthcare Effectiveness Data and Information Set (HEDIS) Effectiveness of Care and Access/Availability of Care performance measures specific to screening and preventive care were reported and reviewed. The following screenings were successfully utilized as indicated by HEDIS data and provide benchmarking metrics for future improvement initiatives.

- Cervical Cancer Screening (CCS)
- Cholesterol Management for High-Risk Populations
- Comprehensive Diabetes Care (CDC): Comprehensive screenings include Hemoglobin A1c testing, retinal eye exam LDL-C Screening and medical attention for neuropathy
- Antidepressant Medication Management (AMM)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD): including both the Initiation Phase and Continuation & Maintenance (C&M) Phase
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
- Mental Health Utilization (MPT)
- Prenatal and Postpartum Care (PPC)

The following screenings were compared year over year in aggregate, from 2014 to 2015 with the following overall average comparison:

- Breast Cancer Screening: The percentage of screenings increase by 6% from 2014 to 2015.
- Asthma Management: Rates for Use of Appropriate Medications for People with Asthma made significantly increased 20% for all ages from 2014 to 2015, with an increase in each age band.
- Preventive Care Visits: Adults' Access to Preventive/Ambulatory Health Services increased 5% from 2014 to 2015.

- Preventive Care Visits: Children and Adolescents' Access to Primary Care Practitioners average rate significantly increased 20% from 2014 to 2015.
- Annual Preventive Dental Visits: The average rate increased 8% from 2014 to 2015.
- Follow-Up After Hospitalization for Mental Illness (7 days): The average rate increased from 7% from 2014 to 2015.
- Follow-Up After Hospitalization for Mental Illness (30 days): The average rate increased from 6% from 2014 to 2015.
- Antidepressant Medication Management: The average rate for both the acute phase and the continuation phase remained flat from 2014 to 2015. This measure assisted in identifying medication adherence as metric within the next QMS.

4

GOAL #2: PHYSICAL AND BEHAVIORAL HEALTH INTEGRATION

The integration of behavioral health with the physical health aspects of care for all GHP Enrollees was and continues to be an important goal to ensure that care receive is holistic. The goal of integrated care was initially developed to promote valuing the importance of both physical and behavioral equally, and to decrease any stigma associated with behavioral health needs. One avenue to succeed in integrating care is to elevate the access to behavioral health care.

For GHP Enrollees in Puerto Rico a colocation and reverse colocation model was established. The colocation model requires a behavioral health provider embedded within a primary care setting to enable enrollees to receive integrated care at one setting. For reverse colocation, the integrated care model requires certain physical health services are available to Enrollees being treated in behavioral health settings.

Through Performance Improvement Plans (PIPs) that were conducted by APS, the MBHO for GHP and in collaboration with the physical health MCOs behavioral health integration was reviewed. The most recent PIPs focusing on PH-BH integration include the following:

- Obesity and Depression
- Well-being of Members with Autism and ADHD
- Diabetes and Depression

Obesity and Depression

Enrollees were identified for this study by inclusion of those who were 18 years of age and older with a BMI greater than or equal to 30 and had either a depression diagnosis or a PHQ-9 score equal to or greater than 10. The measurement tool used was the depression screening tool, Patient Health Questionnaire (PHQ-9). The process included identifying the membership with obesity and depression and increase mental health services for the identifying population. A PHQ-9 screening was obtained pre- and post- interventions.

Interventions included the enhancement of patient self-care by providing patient education, psychological services, and facilitation of Enrollee access to services including prevention services and prescription drugs as needed.

The PIP concluded that a significant improvement in patient’s symptoms was observed with a reduction of symptoms from moderately severe (PHQ-9 mean score of 14) to minimal symptoms (PHQ-9 mean score of 7). The results support the positive effect of an integrated approach and the support for preventive screenings and referrals.

Well-being of Members with Autism and ADHD

The goal of this PIP was to prevent maladaptive behaviors in enrollees with autism and ADHD through parent education. To identify the population any Enrollee that was four years old and older with a combination of diagnosis codes for autism and ADHD.

Once the population was established, patient education was provided to the parents/guardian and the Enrollee as appropriate. The education was aimed to facilitate development and learning, promote socialization, and reduce maladaptive behaviors. Families were guided on behavior modification techniques via follow-up calls, mailings and educational materials.

To measure the results of the education plan, a “pre” and “post” test was given. The results revealed that there was an increased in knowledge of behavior modification strategies and that a subpopulation of the parents utilized supportive groups as an additional support.

Diabetes and Depression

Enrollees were identified for this study by inclusion of those identified with a diagnosis of diabetes through the disease management program and had either a depression diagnosis or a PHQ-9 score equal to or greater than 10. The measurement tool used was the depression screening tool, Patient Health Questionnaire (PHQ-9). The process included identifying the membership with diabetes and depression and increase mental health services for the identifying population. A PHQ-9 screening was obtained pre- and post- interventions.

Interventions included the enhancement of patient self-care by providing patient education, psychological services, and facilitation of Enrollee access to services including prevention services and prescription drugs as needed.

The results indicated a decrease of depressive symptoms as evidences by a “pre” PHQ-9 average score of 16 and “post” PHQ-9 scores averaging 6.

5

GOAL #3: MEMBER’S EXPERIENCE AND SATISFACTION

The Puerto Rico program includes surveys for Enrollee experience and satisfaction. Surveys help identify Enrollee experience of care and provider experience working with the MCOs. The most common survey is the National Committee for Quality Assurance’s (NCQA) Consumer Assessment of Healthcare Providers and Systems (CAHPS). The CAHPS survey is tailored to adult and child populations, including special supplements for Children with Chronic Conditions.

Analysis and Recommendations for Member Experience Activities

The CAHPS and the ECHO BH Survey data are essential to understanding how the GHP program is operating. Survey data can provide necessary benchmarks, uncover the “why” behind perceptions and give a voice to consumers. However, it should be balanced against the potential for survey fatigue. Survey fatigue is often described as when survey respondents become bored, tired or uninterested, resulting in the survey becoming less valuable. The CAHPS surveys performed in Puerto Rico included both adult and child reports and the ECHO BH Survey included adults. All surveys were offered in both English and Spanish.

Feedback obtained from the CAHPS survey included a summary of the effectiveness of care measures as they relate to smoking cessation, flu vaccinations, aspirin use in the primary prevention of cardiovascular disease and shared decision making. The CAHPS survey also encompasses questions involving provider and MCO satisfaction. Across the MCOs the provider satisfaction of a Personal Doctor and of Specialist have been consistently above the 90th percentile. Satisfaction with the Health Plan has been consistently above the 50th percentile. The charts below summarize the satisfaction scores from the most recent surveys. First Medical results are reported using a 0-3 scales versus a percentage for measures with the exception of shared decision making.

ADULT	MMM 2015	MMM 2016	MHPR 2016	MHPR 2017	TRIPLE-S 2017	FM 2017
Rating of all Health Care	69.70%	67.20%	73.30%	75.40%	75.30%	2.35
Rating of a Personal Doctor	82.80%	79.90%	87.50%	86.00%	82.30%	2.48
Rating of Specialists seen most often	83.60%	86.90%	89.80%	92.10%	84.40%	2.72
Rating of Health Plan	67.10%	68.60%	69.20%	77.30%	76.00%	2.41

ADULT	MMM 2015	MMM 2016	MHPR 2016	MHPR 2017	TRIPLE-S 2017	FM 2017
Getting Needed Care	70.10%	68.10%	79.70%	80.30%	79.10%	2.35
Getting Care Quickly	71.00%	73.10%	79.50%	79.90%	81.60%	2.33
How Well Doctors Communicate	91.40%	89.00%	93.20%	91.40%	89.40%	2.58
Customer Service	85.50%	84.10%	85.50%	89.50%	86.90%	2.43
Shared Decision Making	65.30%	68.40%	75.60%	73.70%	73.60%	75.60%

CHILD	MHPR 2016	MHPR 2017	FM 2017	MHPR CCC 2016	MHPR CCC 2017
Rating of all Health Care	80.70%	82.60%	2.47	79.80%	82.50%
Rating of a Personal Doctor	86.90%	90.40%	2.69	86.80%	88.80%
Rating of Specialists seem most often	88.70%	89.20%	2.73	83.40%	88.40%
Rating of Health Plan	70.90%	79.90%	2.44	66.20%	73.90%
Getting Needed Care	85.10%	83.60%	2.28	80.50%	81.90%
Getting Care Quickly	83.80%	86.50%	2.38	82.90%	86.40%
How Well Doctors Communicate	92.20%	92.60%	2.65	89.40%	92.20%
Customer Service	86.20%	89.60%	2.5	84.70%	90.40%
Shared Decision Making	67%	67.10%	66.50%	70.80%	74.20%

6

PUBLIC/STAKEHOLDER COLLABORATION

ASES consistently includes stakeholder feedback into the quality management strategy. Each of the MCOs held quarterly regional advisory boards where all enrollees and providers were invited to participate and the invitation to the meetings were disseminated in the following ways: An open invitation to all enrollees and providers in the region was posted on the MCO Enrollee and provider web portals. The Customer Service Department including the regional office reception desk had available informative flyers for distribution, both in English and Spanish, with the meeting information. An informative script was provided to the Customer Service Representatives, in order to inform enrollees about the advisory board meeting, as needed.

The advisory meetings allow for an educational opportunity to discuss the purpose and process of the various programs and available courses offered by the MCOs. This assists the providers to achieve the required number of training and education hours. An example is that all MCOs offered trainings regarding the ZIKA virus.

The information shared during the quarterly advisory meetings included updates on utilization and covered services, quality management updates, customer services updates and programmatic updates regarding the integration of behavioral and physical health. Feedback received during the advisory meetings was recorded and incorporated into the ongoing improvement plans. The process for Quality of Care Issues (QCI) investigations is in place for the MCOs to receive and evaluate situations that impact health services and are typically referred through each MCO's grievances and appeals process. A review is completed by each MCO that includes a medical record review to review for appropriate quality and clinical standards. If unacceptable, a corrective action plan may be initiated. This process was shared during the advisory committees and any reviews that took place were summarized.

7

CONCLUSION

The QMS and this evaluation provides guidance and oversight to advance island-wide quality improvement through a focus on performance improvement aimed at increasing the use of preventive care and appropriate delivery of care in a timely manner. The strategies set the course for programmatic changes that will enhance the overall well-being of the GHP membership. The information obtained through the quality strategy and evaluation has helped identify areas of strength and areas for further focus within the GHP program including the goals of preventive care and Enrollee satisfaction as core values to the health care initiatives for GHP. Going forward, Puerto Rico is taking a targeted approach to the membership with high-cost high needs.

Puerto Rico's approach to its QMS for 2018 was revised to focus on the following three goals that will be analyzed as part of the next QMS evaluation:

- Improve preventive care screening, access of care and utilization of health services for all GHP eligible enrollees.
- Improve quality of care and health services provided to all GHP eligible enrollees through the HCHNs program.
- Improve Enrollee's satisfaction with provided services and primary care experience.

It is Puerto Rico's belief that by focusing performance improvement activities on those most in need of intervention, those with high-cost conditions, high need and socioeconomic factors and promoting the use of evidence based practices all under an integrated model will result in meaningful and sustained improvements. As Puerto Rico continues to systemize the quality improvement activities throughout the year, new measures may be added, as needed, to effectuate improvement and to ensure that high quality of care is achieved through an iterative quality improvement process.

Puerto Rico has begun a more intense and methodological process for ensuring quality of care is being delivered. Steps have been taken to reduce the number of reports required by the MCOs, data validation practices, and the development of cross-departmental dash boarding. As the QMS evolves and future monitoring and evaluation occurs, the data will not be completely comparable to earlier iterations of the program as service delivery, participation and network requirements have evolved with the GHP model.

Puerto Rico believes that the alignment of goals and objectives, as well as the collaborative approach to continuous quality improvement, will act as an incentive to achieve goals.