ESTADO LIBRE ASOCIADO DE
PUERTO RICO
Administración de Seguros
de Salud de Puerto Rico (ASES)

Normative Letter #15-1222

December 22, 2015

TO: All Managed-Care Organizations Contracted for the Provision of Physical and Behavioral Health Services under the Government Health Plan of Puerto Rico (The "GHP")

HIGH-UTILIZERS PROGRAM (The "Program")

The Puerto Rico Health Insurance Administration (ASES, for its acronym in Spanish) is the public corporation of the Commonwealth of Puerto Rico with the responsibility to implement, administer, and negotiate the health insurance system for the medically-indigent sector of our population by means of contracts with Managed-Care Organizations (MCO's).

In its search for initiatives to improve the healthcare services provided to its beneficiaries, while at the same time dealing with the rising costs of the entire system, ASES identified a very promising project, mainly originated and developed by Dr. Jeffrey Brenner, CEO of the Camden Coalition of Healthcare Providers, directed at a specific group of enrollees, denominated High-Utilizers. These High-Utilizers are patients who fall through the "cracks" of the System and whose complex physical, behavioral, and social needs are not being met through the current case management services contracted. As the term implies, they have less than promising state of health, while costing much more in services than the rest of the population; by definition, High-Utilizers are this group within the population, which with a different healthcare approach, one which is patient-centered, can be "impactable", thus improving significantly there health, and reducing their high costs.

In 2013, the Governor of Puerto Rico responded to an RFP made public by the National Governors Association (the "NGA"), which offered technical support to selected US Jurisdictions, in the development and implementation of High-Utilizer Programs. Puerto Rico was among the 7 Jurisdictions selected and so, ASES and the then Third Party Administrator Triple S employees participated for over a year in different seminars and policy academies in Puerto Rico and Mainland US, receiving assistance from the leading experts in the Nation in such programs.

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For over a year, ASES has been directing a High-Utilizers Program under the avail and guidance of CMS and the Governor of Puerto Rico. But with the replacement of the healthcare delivery model for the Medicaid Population in Puerto Rico, which came to place in April 1st, 2015, and the role of Triple-S changing from being the TPA for all the regions in Puerto Rico to an MCO providing services for two (2) regions, and four (4) other MCOs delivering such services to the GHP Beneficiaries, in order to ensure stable and sound continuity of this Program, CMS approved that Triple-S be maintained as the Administrator until June 30th, 2017.

ASES is issuing this Normative Letter in order to guarantee the needed collaboration between the other MCOs in the GHP, ASES, Triple-S and any other stakeholders related to the Program. It is to be jointly considered with Normative Letter #14-0606A (enclosed) and Article 7.14 of the Contracts by and between ASES and the MCOs, as well as any other guidelines provided by ASES, and all applicable Federal and State Law and Regulations.

Cordially

Ricardo A. Rivera Cardona
Executive Director

Enclosure
Normative Letter #14-1606A

ESTADO LIBRE ASOCIADO DE
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de Salud de Puerto Rico (ASES)

ATTACHMENT 25

NORMATIVE LETTER #14-0606A (amended on August 1, 2015)

TO: TRIPLE-S SALUD INC. (the "Contractor")

HIGH-UTILIZERS PROGRAM (The "Program")

The Program serves as a means for achieving enrollees' wellness and autonomy through care coordination, education, identification of service resources, and service facilitation in a cost-effective way. Through the Program, the Contractor ensures that an enrollee with intensive needs, including catastrophic or high-risk conditions, receives needed services in a supportive, effective, efficient and timely manner. Included in this category are enrollees classified as High-Utilizers. The term High-Utilizer describes enrollees whose complex physical, behavioral, and social needs are not met through the current case management services. As a result, these individuals often go from emergency department to emergency department (EDs) and/or from inpatient admission/discharge to readmission.

Through this Normative Letter, the Puerto Rico Health Insurance Administration (ASES, for its acronym in Spanish) establishes the criteria for identifying High-Utilizers and providing them with specialized effective care coordination services. The Program's goals are focused on the following areas:

1. Identify the High-Utilizer population, as defined by ASES' methodology *(see Attachment A).*
2. Build integrated initiatives, combining physical and behavioral health with social needs.
3. Create partnerships at state, regional, and local levels to leverage resources across governmental agencies such as the Department of Health, the Department of Family and Social Services, Housing, Transportation among others, extending to the private sector and non-profit organizations.
4. Develop meaningful data on the super-utilizer population that can drive interventions and measure their success.
5. Provide monthly utilization and quality reports which inform changes and improvements on utilization trends for the identified members.

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I. Program Process:

1. ***Case Identification-*** ASES will select the top 1,000 utilizers per region (8,000 island-wide). The selection criteria are established in ***Attachment A*** of this Normative Letter.

2. ***High-Utilizers Management-*** All enrolled members will be administered a Health Risk Assessment (HRA) which will assist in the identification of the members' healthcare needs. The HRA shall be submitted to ASES by the Contractor for approval. The Contractor shall establish baseline measures for each member, such as BMI, Blood Pressure, Hemoglobin A1c, and other clinical measures. These baselines measures shall be monitored on a continuous basis, in order to track quality improvement and personalized care plan.

3. ***Medical Oversight-*** The Contractor's Medical Directors and Case Management Teams will have oversight of each case, will communicate, coordinate, and educate the providers involved in the care of the member, including Primary Care Physicians' (PCPs) partners. The Case Management Team, and a Multidisciplinary Team composed of social workers, psychologists, outreach personnel, nutritionists, and nurses, together with physicians, will work to remove social and behavioral barriers to care by coordinating with available government services and community interventions.

4. ***Member Education-*** The Contractor shall educate members in the Program, as well as their Primary Care Medical Group, to ensure that once these members finish their participation, they will continue having control of their care and their social and behavioral issues. Once the patients end their participation in the program, the Contractor shall continue monitoring them, to ensure that their conditions remain under control.

5. ***Coordination of Services/Transitions of Care-*** For members admitted into hospitals, the Contractor will provide direct support with medical coordination and visits to each member. The Case Managers will follow the discharge plan to ensure the member will have the necessary medications and equipment at discharge to reduce the possibility of re-admission.

II. Reporting Requirements:

The Contractor will provide a monthly report to ASES on each the specified categories. The results shall be monitored both at an individual (per patient) and global level (group enrolled in the program as well as the patients exiting the program). The Contractor must keep a baseline record for each patient on each of the categories, which shall include the past 12 months' historical data of the patient before entering the Program. After the patient begins the Program, the Contractor shall keep track of him and submit reports on a monthly basis for the specified categories, which will provide the results for each month, as well as the cumulative ones(from when the patient started in the program up to that month). Comparisons must be established and tracked between the monthly, cumulative, and baseline data. The categories are, but not limited

to, the following (utilization management measurements, quality measurements, and member satisfaction measurements):

A. Utilization Management Measurements:

1. Total Cost – Total cost and total cost per member for the period. This cost includes all components: physical and behavioral health services provided, as well as prescription drugs.

2. Hospitalizations – Total number of hospitalizations, average length of stay (ALOS), total cost of hospitalizations, hospitalizations and cost per member for the period, an top reasons/conditions for hospitalizations at individual and aggregate levels.

3. ED Visits – Total number of visits to ED, total cost of ED visits, and visits and ED cost per member for the period, in addition to the top reasons/conditions for ED visits at individual and aggregate levels.

4. Pharmacy Utilization – Total number of prescriptions, cost of prescriptions, and number and cost of prescriptions per member for the period, in addition to the top conditions treated at the individual and aggregate level.

B. Quality Measurements- The frequency of the quality measurements will be determined by the multidisciplinary team on a case by case and taking in consideration the condition to maximize resources.

1. For All Members:
   - Quality of Life indicators similar to SF36
   - Follow-Up after hospitalization
   - Medication reconciliation
   - Depression screening (PHQ9)
2. For Members With Diabetes:
   - Blood sugar control (Hbg A1C <8)
   - Flu and Pneumococcal Vaccine
3. For Members With Heart Failure:
   - Compliance with medication therapy
   - Flu and Pneumococcal Vaccine

4. For Members With Hypertension Conditions:
    - Blood pressure less than 140/90
    - LDL cholesterol less than 100
    - Flu and Pneumococcal Vaccine
5. For Members With Asthma Conditions:
    - Members using controllers (ICS medications)
    - Flu and Pneumococcal Vaccine

C. Member Satisfaction Measurements:

- Annual surveys will be conducted to measure member satisfaction, in a manner similar to the ones being conducted by the Camden Coalition of Healthcare Providers.

III. High-Utilizers Team:

The Contractor, with the approval of ASES, will be responsible of assembling a High-Utilizers Team that includes, but is not limited to a: Program Director, Medical Director, Resource Center Director, Nurse Supervisor, Registered Nurses, Health Service Representatives, Social Workers, Psychologists, Nutritionists, and Health Educators. The High-Utilizers Team will be responsible of selecting members (based on the established criteria and "impactability"), creating plans of care with both clinical and social/behavioral interventions, educating members and providers, executing plans of care, and coordinating services with the Stakeholders.

The Stakeholders shall be, but are not limited to: ASES, MCOs, Hospitals, Physicians/PCPs, Medical Groups, Specialists, Mental Behavioral Health Organizations (MBHOs), Laboratories, Pharmacies, Pharmaceutical Companies, Government Agencies (Health Department, Education Department, Family Services Department, Housing Department, Power and Water Authorities, among others), and Community Resources (private institutions, charitable organizations, social and educational organizations, foundations, associations, municipalities programs, among others).

Ricardo A. Rivera Cardona
Executive Director

ATTACHMENT A- NORMATIVE LETTER #14-0606A:

IDENTIFICATION PROCESS

FOR HIGH-UTILIZERS

Selection Criteria

1. The identification of the target population for the Program is based on a score that will be computed based on the utilization:
    a. Number of ED visits
    b. Number of hospital admissions
    c. Total paid cost of physical health services (excluding dental health services)
    d. Number of prescriptions related to physical health conditions
    e. Total cost of behavioral health services

2. Each value of these metrics will be standardized using Z-score.[1] The analysis will be done on a regional basis.

3. Values with three or more standards deviations from the average (positive values) will be considered outliers.

4. The cases will be clustered in three levels:

    a. High – three or more standards deviations from the average – 3 points
    b. Moderate – from two to less than three standards deviations from the average– 2 points
    c. Low – less than two standards deviations from the average– 1 point
    d. Negative standard deviations - 0 point

5. The scores obtained in subsection four will be summed to obtain a total score. The top 1,000 scores of each region will be selected.

6. If two or more cases have the same score, the cases will be selected in the following order:
    a. Total cost of physical health services (excluding dental health services)
    b. Total cost of mental health services
    c. Number of ED visits
    d. Number of hospital admissions
    e. Number of prescriptions related to physical health conditions

[1] The *z-score* gives the position of the value relative to the remainder data. The most obvious outliers in a data set are those that fall more than three standard deviations from the mean. If the z-score is greater than +3 or less than –3, those values are outliers.