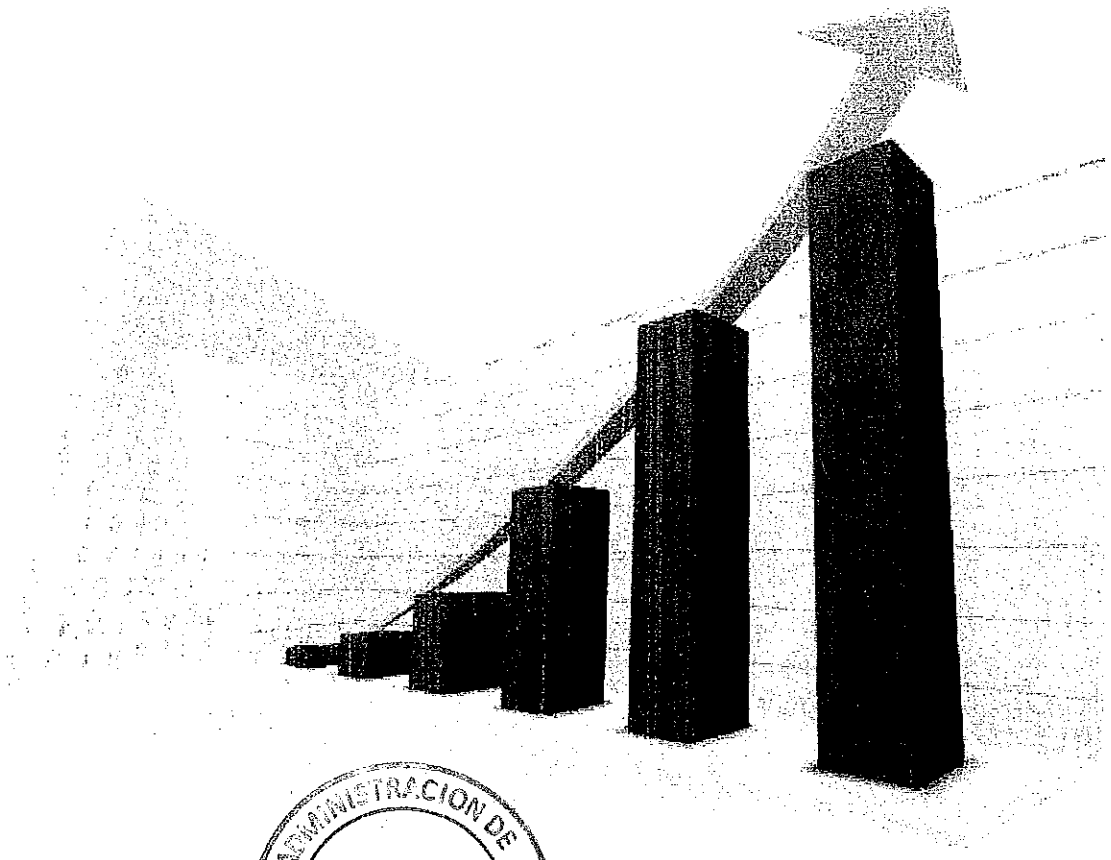
PUERTO RICO HEALTH INSURANCE ADMINISTRATION
COMMONWEALTH OF PUERTO RICO
PLANNING AND QUALITY AFFAIRS OFFICE

QUALITY INCENTIVE PROGRAM

FY 2017



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I. INTRODUCTION

The Puerto Rico Government Health Plan (GHP) is focus on providing quality care services that are patient centered aimed at increasing appropriate use of screening and prevention delivered in a timely manner to all *Medicaid, Children's Health Insurance Program (CHIP) and Medicare-Medicaid Dual Eligible enrollees* in Puerto Rico.

This Quality Improvement Procedure Manual has the sole purpose of providing the necessary guidelines for attaining the required performance indicators for each of the categories measured under the Quality Incentive Program (QIP), as described in Article 12 of the contract executed between the MCO and the Puerto Rico Health Insurance Administration (ASES, by its acronym in Spanish). ASES shall maintain a Retention Fund of the Per Member per Month (PMPM) each month as part of the QIP described in Section 12.5.3. A portion of the retained amount shall be associated with each of the QIP initiatives outlined below:

- Performance measures (Section 12.5.4.1)
- Preventive Clinical Programs (Section 12.5.4.2)
  - ✓ Physician Incentive Program
  - ✓ Disease Management Program
- Emergency Room Use Indicators (Section 12.5.4.3)

ASES will reimburse the MCO according to compliance with each of the categories of performance indicators in section 12.5. The Planning and Quality Affairs Office will audit the results of the data in the timeframes stated in Section 12.5 of the Contract for the performance indicators in the following categories: Performance measures, Preventive clinical program measures, and ER Utilization measures. This Manual describes in detail the requirements and the specific metrics for each category of the Quality Incentive Program. The Quality Improvement Procedure Manual will enter in effect the Effective Date of the Contract and will be revised every contract year at ASES' discretion unless required in another timeframe by law or regulation.

Definition reference in this manual are from the Puerto Rico Health Insurance Administration Contract and NCQA (National Committee for Quality Assurance)

II. REPORTING TIMEFRAMES

Quarter	Incurred Service Time Period	Payment as of	Submission Date
	Baseline Data Analysis: Calendar Year 2016*		August 30, 2017
Q1	7/1/2017 through 9/30/2017	December 31, 2017	January 30, 2018
Q2	10/1/2017 through 12/31/2017	March 31, 2018	April 30, 2018
Q3	1/1/2018 through 3/30/2018	June 30, 2018	July 30, 2018
Q4	4/1/2018 through 6/30/2018	September 30, 2018	October 30, 2018

***For Performance Measures, the baseline may be adjusted removing members that have reach compliance from January 1st to June 30, 2017.**

III. EVALUATION & POINT DISTRIBUTION

The evaluation process of the QIP is divided in three categories; Performance Measures, Preventive Clinical Programs and Emergency Room Quality Incentive Program. This evaluation methodology has been developed to meet the requirements established in section 23.1 of the GHP Contract. The scale of values per indicator as determined by ASES, is divided in three levels as follows:

For metrics with a value of two (2) points:

- 2 Points = Full compliance with expected goal, meets or exceeds (90%-100%) expected goal as define in the QIP Manual.
- 1 point = Partial compliance, results reported are 70% or over but less than 90% (70.00% - 89.99%) of the established goal.
- 0 point = Fails; results reported are less than 70% (0% - 69.99%) of the established goal.

For metrics with a value of 1 (1) point:

- 1 Points = Full compliance with expected goal, meets or exceeds (90% - 100%) expected goal as define in the QIP Manual.
- O.5 point = Partial compliance, results reported are 70% or over but less than 90% (70.00% - 89.99%) of the established goal.
- 0 point = Fails; results reported are less than 70% (0% - 69.99%) of the established goal.

The point distribution by program is as follows:

Program	Points
Performance Measures	16
Preventive Clinical Programs	31
ER Quality Incentive Program	5

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IV. RETENTION FUND & COMPLIANCE PERCENTAGE

ASES will withhold a portion of the PMPM otherwise payable to the MCO in order to incent the MCO to meet performance targets under the Quality Incentive Program. The retention fund will be reimbursed to the MCO when a determination is made by ASES that the MCO has complied with the quality standards and criteria established by ASES in accordance with 23.1 of the contract. On a quarterly basis the MCO will submit a quarterly *Retention Fund Report* in accordance to 18.2.9.4 of the contract.

On a monthly basis, ASES will withhold a retention fund equivalent to two (2) percent of the total PM/PM of each region. A portion of the retained amount will be associated with each of the Quality Incentive initiatives outlined below for each of the specified timeframes as per section 22.4.1 of the contract:

Time Period (Incurred service from Contract Term)	Monthly Retention Fund Percentage
7/1/2017 through 6/30/2018	2%
QIP Initiative	**Retention Fund Breakdown**
Performance Measures	40%
Clinical Programs	30%
Emergency Room Use Indicators	30%

No later than thirty (30) calendar days after receipt of the Contractor's quarterly reports, ASES shall determine if the MCO has met the applicable performance objectives for each quality incentive initiative for that period. The evaluation result and compliance will determine the percent to be disbursed to the MCO as described in the following table:

Compliance Percent	Disbursement Percentage of Monthly PM/PM
100-90%	100%
89.9-80%	75%
79.9-70%	50%
69.9 and below %	0%

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For the first quarter (July 1st to September 30, 2017), ASES will reimburse corresponding period retention fund subject to the submission of the required reporting templates regardless of the compliance with the established goals. This waiver is provided to allow the MCOs to finish the programming, population identification, develop strategies, communication to providers, start interventions with identified members and all other activities related to this QIP necessary to comply with its requirements.

Definition reference in this manual are from the Puerto Rico Health Insurance Administration Contract and NCQA (National Committee for Quality Assurance)

V. DEFINITIONS

The following definitions apply to measures of the Quality Improvement Manual:

1. **Disease Management:** An administrative function comprised of a set of Enrollee-centered steps to provide coordinated care to Enrollees suffering from diseases listed in Section [7.8.3] of the Contract.
2. **Hot Spotting:** The ability to identify in a timely manner heavy users of the systems and their patterns of utilization to provide targeted interventions and care through mapping data.
3. **Incurred date:** Is the date in which the service was provided.
4. **Intervention:** activities targeted at the achievement of client stability, wellness, and autonomy through advocacy, assessment, planning, communication, education, resource management, care coordination, collaboration, and service facilitation.
5. **Performance measures:** periodic measurement of outcomes and results used to assess the effectiveness and efficiency of quality initiatives on selected indicators.
6. **Per member per month payment (PMPM):** The fixed monthly amount that the MCO is paid by ASES for each enrollee to ensure that benefits under the Contract are provided. This payment is made regardless of whether the enrollee receives benefits during the period covered by the payment.
7. **Preventive Services:** Health care services provided by a physician or other provider within the scope of his or her practice under Puerto Rico law to detect or prevent disease, disability, behavioral health conditions, or other health conditions; and to promote physical and behavioral health and efficiency.
8. **Primary Care Physician:** A licensed medical doctor (MD) who is a provider and who, within the scope of practice and in accordance with Puerto Rico Certification and licensure requirements, is responsible for providing all required primary care to enrollees. The PCP is responsible for determining services required by enrollees, provides continuity of care, and provides referrals for enrollees when medically necessary. A PCP may be a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.
9. **Retention Fund:** The amount of withhold by ASES of the monthly Per Member **per** Month Payments otherwise payable to the MCO in order to incentivize the MCO to meet performance targets under the Quality Incentive Program described in Section [12.5.3]. This amount shall be **equal to** the percent of that portion of the total Per Member **per** Month Payment that is determined to be attributable to the MCO's administration of the Quality Incentive Program described in Sections [12.5 and 22.3]. Amounts withheld will be reimbursed to the MCO in whole or in part (as set forth in Sections [12.5 and 22.3]) in the event of a determination by ASES that the MCO has complied with the quality standards and criteria established by Section [12.5].
10. **Special Coverage:** A component of Covered Services provided by the MCO, described in Section [7.7], which are more extensive than the Basic Coverage services, and for which Enrollees are eligible only by

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"registering." Registration for Special Coverage is based on intensive medical needs occasioned by serious illness.

11. **Quality Incentive Program:** mechanism to improve the quality of services provided to Enrollees. The program shall consist of three (3) categories of performance indicators: performance measures, preventive clinical program measures and ER Utilization measures.

12. **Active Member:** GHP member with **continuous** enrollment during the measurement quarter.

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VI. PERFORMANCE MEASURES

The reporting templates for each of the performance measures mentioned below will be provided to the MCO through the ASES ShareFile site. Each reporting template will be in Excel format. ASES shall reimburse the MCO the percent applicable of the Retention Fund, as shown on page 3, in accordance with Section 22.3 of the contract for successful compliance with the performance measures below based upon quarterly evaluation of this criterion. The MCO shall demonstrate an increase in the measurement year as described in the next table, for the following performance measures:

- PM1. Breast Cancer Screening
- PM2. Cervical Cancer Screening
- PM3. Cholesterol Management
- PM4. Diabetes Care Management
- PM5. Access to Preventive Care Visits
- PM6. Asthma Management
- PM7. Follow up after Hospitalization for Mental Health

The Performance Measures reports are based on claims incurred in the measurement period for each region. The MCO shall provide data for each region.

For each reported submission, the MCO shall use the same template that was submitted in previous quarter(s). The MCO may not update data submitted for previous reporting periods.

The MCO will report the amounts individually for each quarter. For evaluation purposes, to determine compliance, ASES will consider cumulative percentages by quarter (roll over). In the event that the MCO achieve the annual goal before the last quarter of the year, the MCO must demonstrate at least any increase in the percentage during the remaining quarter(s).

Definition Requirements by Performance Measure

(Codes are subject to continuous update revision)

PM1. Breast Cancer

Breast Cancer	
Definition for Baseline	Total women 50–74 years of age who has not have a mammogram to screen for breast cancer any time on the year prior the measurement year.
Numerator	The number of active women with a Breast Cancer Screening during the measurement period.
Denominator	Indicate the number of active women without a Breast Cancer screening the year prior to the measurement period for whom the screening has not been performed during previous quarters.
Codes	ICD-10-CM Diagnosis: Z12.31 CPT CODES: 77055,77056, 77057 HCPCS: G0202, G0204, G0206

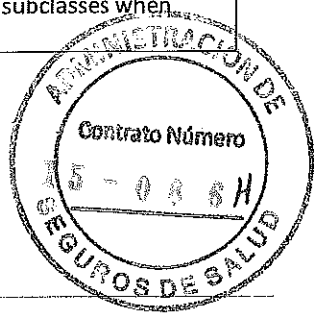
Definition reference in this manual are from the Puerto Rico Health Insurance Administration Contract and NCQA (National Committee for Quality Assurance)

PM2. Cervical Cancer Screening

Cervical Cancer	
Definition for Baseline	Total of women 21–64 years of age who were not screened for cervical cancer the year prior to the measurement year.
Numerator	The number of active women in the denominator with a cervical cancer screening during the measurement year.
Denominator	Indicate the number of active women without a Cervical cancer screening the year prior to the measurement period for whom the screening has not been performed during previous quarters.
Codes	ICD-10-CM Diagnosis: Z12.4 CPT CODES: 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175 HCPCS: G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091

M3. Cholesterol Management

Cholesterol Management	
Definition for Baseline	Total members 18-75 years with a high risk diagnose who have not had a LDL-C test during year prior to the measurement period.
Numerator	Numerator 1: Indicate the number of active members in the denominator with Diabetes Mellitus and a LDL-C test done during the measurement period. Numerator 2: Indicate the number of active members in the denominator with a Cardiovascular Condition and a LDL-C test done during the measurement period. Numerator 3: Indicate the number of active members in the denominator with Arterial Hypertension and a LDL-C test done during the measurement year.
Denominator	Denominator 1: Indicate the number of active members with Diabetes Mellitus and without a LDL-C test done the year prior to the measurement year for whom the screening has not been performed during previous quarters. Denominator 2: Indicate the number of active members with a Cardiovascular Condition and without a LDL-C test done the year prior to the measurement year for whom the screening has not been performed during previous quarters. Denominator 3: Indicate the number of active members with Hypertension and without a LDL-C test done the year prior to the measurement year for whom the screening has not been performed during previous quarters.
Codes	ICD-10-CM Diagnosis: Z13.220 & Codes for DM (E10 y E11), CVD (I70, I175), HBP (I10, I11, I12, I13, I15) CPT CODES: 80061 - Lipid Panel, 82465 Cholesterol, 83718 HDL Cholesterol, 83719 LDL, 83721 VLDL, 84478 Triglycerides , 83698 Lipoprotein Associated Phospholipase A2, 83700 Lipoprotein, blood; electrophoretic, 83704 quantitation of lipoprotein particle numbers and lipoprotein subclasses when measured.



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PM4. Diabetes Care Management

Diabetes Care Management	
Definition for Baseline	Total members 18-75 years of age with Diabetes Mellitus (E10 Type 1 Diabetes Mellitus or E11 Type 2 Diabetes Mellitus) who have not had each of the following the year prior the measurement period: Comprehensive Diabetes Care (CDC): • Hemoglobin A1c (HbA1c) testing • Eye exam (retinal) performed by an eye care provider (Z01.01 Encounter Examination of eye) • Medical attention for nephropathy – either evidence of nephrology medical evaluation or a nephropathy screening test
Numerator	The number of active members in the denominator who have had a HgA1c Test, Eye Exam and Nephropathy Screening Test during the measurement period.
Denominator	HgA1c Test Denominator: Indicate the number of active members without a HgA1c test the year prior to the measurement year for whom the screening has not been performed during previous quarters. Eye Exam Denominator: Indicate the number of active members without an Eye Exam the year prior to the measurement year for whom the screening has not been performed during previous quarters. Nephropathy screening test (Urine Microalbumin Testing) Denominator: Indicate the number of active members without a Microalbumin test the year prior to the measurement year for whom the screening has not been performed during previous quarters.
Codes	ICD-10-CM Diagnosis Diabetes: Use the appropriate code family: E10, E11 **HbA1C Testing** CPT CODES 83036, 83037, CPT II Codes 3044F (<7.0%), 3045F (7.0-9.0), 3046F (>9%) **Nephropathy Screening** CPT CODES: 3060F, 3061F, 3062F, 3066F, 4010F Nephropathy Screening test:82042, 82043, 82044, 84156 Nephropathy Exclusion: CKD stages 4 and 5 **Retinal Eye Exam** CPT CODES: 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240,92250, 92260, 99203-99205, 99213-99215, 99242-99245 CPT II: 2022F, 2024F, 2026F, 3072F HCPCS S0620, S0621, S0625, S3000

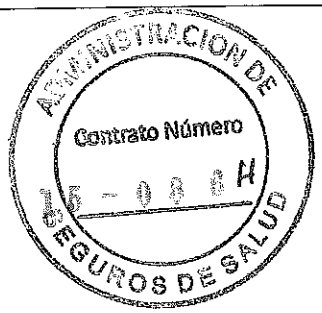
Definition reference in this manual are from the Puerto Rico Health Insurance Administration Contract and NCQA (National Committee for Quality Assurance)

PM5. Access to Preventive Care Visits

Access to Preventive Care Visits	
Definition for Baseline	Total members who have not had at least one preventive care visit with a PCP the year prior during the measurement period.
Numerator	The number of active members in the denominator with a preventive care visit with a PCP during the measurement period.
Denominator	Indicate the number of active members without a preventive care visit with a PCP the year prior to the measurement period for whom the screening has not been performed during previous quarters.
Codes	ICD-10-CM Diagnosis "General Medical Exam:Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9 " ICD-10-CM Procedure Other Exams: Z00.5, Z00.8, Z02.0, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9 CPT CODES: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99214, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 HCPCS G0402, G0438, G0439, G0463, T1015

PM6. Asthma Management

Asthma Management	
Definition for Baseline	Percentage of members with at least one monthly prescription of drugs use for prevention of bronchial asthma, of all members identified with a reported medical evaluation with a diagnosis of Persistent Moderate or Severe Bronchial Asthma during the baseline year 2016.
Numerator	The amount of members with at least one monthly prescriptions of drugs used for Bronchial Asthma prevention, on active members identified on baseline, with Moderate or Severe Persistent Bronchial Asthma diagnosis during the reporting period.
Denominator	The number of active members on baseline, who are identify with Moderate and Severe persistent Bronchial Asthma for the reporting period.
Codes	ICD-10-CM Diagnosis: J45.4; J45.5 Drugs for prevention of Bronchial Asthma to be provided with the NDC codes.



Definition reference in this manual are from the Puerto Rico Health Insurance Administration Contract and NCQA (National Committee for Quality Assurance)

PM7. Follow up after Hospitalization for Mental Health

Follow up after Hospitalization for Mental Health	
Definition for Baseline	Percent of members who were discharge of acute mental health care facility and were seen on an outpatient basis by a psychiatrist or a physician within thirty days after discharge.
Numerator	The number of discharges in the denominator followed by an outpatient encounter with a psychiatrist or a physician within thirty days after discharge. (This amount shall include visits performed 30 days after the end of the quarter.)
Denominator	The number of discharges from an acute mental health care facility during the quarter.
Codes	ICD-10 F32.0 – F32.4, F32.9, F33.0-F33.3, F33.41, F33.9

Definition reference in this manual are from the Puerto Rico Health Insurance Administration Contract and NCQA (National Committee for Quality Assurance)

The point distribution for each of the measure is as follows:		
Program: Performance Measures	**Improvement Rate Target FY 2017/2018**	**Points**
PM1. Breast Cancer Screening	Calendar year 2016: Baseline Q2-Q4: Incurred services by quarter Goal: 15% improvement Quarterly reimbursement will be based on achieving a minimum of 5% of the established goal on each trimester.	**2 points**
PM2. Cervical Cancer Screening	Calendar year 2016: Baseline Q2-Q4: Incurred services by quarter Goal: 15% improvement Quarterly reimbursement will be based on achieving a minimum of 5% of the established goal on each trimester.	**2 points**
PM3. Cholesterol Management	Calendar year 2016: Baseline Q2-Q4: Incurred services by quarter Goal: 30% improvement Quarterly reimbursement will be based on achieving a minimum of 10% of the established goal on each trimester.	**3 points**
PM4. Diabetes Care Management	Calendar year 2016: Baseline Q2-Q4: Incurred services by quarter Goal: 30% improvement Quarterly reimbursement will be based on achieving a minimum of 10% of the established goal on each trimester.	**3 points**
PM5. Access to Preventive Care Visits	Calendar year 2016: Baseline Q2-Q4: Incurred services by quarter Goal: 15% improvement Quarterly reimbursement will be based on achieving a minimum of 5% of the established goal on each trimester.	**2 points**
PM6. Asthma Management	Calendar year 2016: Baseline Q2-Q4: Incurred services by quarter Goal: 7.5 % improvement Quarterly reimbursement will be based on achieving a minimum increment of 2.5% of the established goal on each trimester.	**2 points**
PM7. Follow up after Hospitalization for Mental Health	Calendar year 2016: Baseline Q2-Q4: Incurred services by quarter Goal: 9% improvement Quarterly reimbursement will be based on achieving a minimum of 3% of the established goal each trimester.	**2 points**
Total points		***16 points***

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VII. PREVENTIVE CLINICAL PROGRAMS

The MCO shall comply with the objectives of each of the following Preventive Clinical Programs as stated in the GHP Contract in section 12.5.4.2. The Preventive Clinical Programs are:

A. DISEASE MANAGEMENT PROGRAM (7.8.3 OF THE CONTRACT)

Disease Management is an approach that aims to provide better care while reducing the costs of caring for the chronically ill. The MCO shall develop a Disease Management Program designed to:

a. Improve the health of persons with specific chronic conditions and
b. Reduce health care service use and costs associated with avoidable complications, such as emergency room visits and hospitalizations.

As a first step, the MCOs Disease Management Program needs to identify the population that will be enrolled in each of the selected conditions. Through a Hot Spotting technique the MCO will provide ASES the demographic characteristics and PMG information of identified members who will benefit from a disease management program.

The second step of the MCO's DM Program is the design of disease management interventions that improve the overall health status of the identified members. The MCO shall develop interventions that impact the following areas: a) Member related (education and patient coaching), b) PCP related (Care Plan discussion and revision) and c) Clinical related measures (UM Review).

For purpose of the Quality Incentive Program Retention Fund, ASES will consider the UM Review metrics described below for compliance and release to the applicable percent of the retained amount for this particular program.

Rule: Report unique patients by category. Patients with multiple conditions will be include only in one Program using the MCO established hierarchy process.

1. **Physical Health DM Metrics**

   A. Percent of Active Severe Members by DM condition

   Formula: Total number (cumulative) of active severe members who are participants in DM by condition during the measurement year/ Total number of severe members identified by DM condition on the baseline.

   Baseline for FY 2017: Calendar year 2016 members identified as DM Candidate in the category of severe. (Candidate is a members diagnose with a DM condition and categorized as severe that is not a participant in the DM Program.)

   The following table defines the baselines, numerator and denominators for the Disease Management conditions to be measured.

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DM Condition	Baseline	Numerator	Denominator
DM1. Asthma (Bronchial Asthma)	Calendar year 2016 Members with the diagnosis of Asthma in the category of severe	Total number of active members with the diagnosis of Asthma in the category of severe who are participants of the DM Program in the measurement period.	Number of active members with the diagnosis of Asthma in the category of severe as identified in the baseline.
DM2. Diabetes Mellitus (Type 1 or 2)	Calendar year 2016 Members with the diagnosis of Diabetes Mellitus (Type 1 or 2) in the category of severe	Total number of active members with the diagnosis of Diabetes Mellitus (Type 1 or 2) in the category of severe who are participants of the DM Program in the measurement period	Number of active members with the diagnosis of Diabetes Mellitus (Type 1 or 2) in the category of severe as identified in the baseline.
DM3. Congestive Heart Failure	Calendar year 2016 Members with the diagnosis of Congestive Heart Failure in the category of severe	Total number of active members with the diagnosis of Congestive Heart Failure in the category of severe who are participants of the DM Program in the measurement period	Number of active members with the diagnosis of Congestive Heart Failure in the category of severe as identified in the baseline.
DM4. Arterial Hypertension	Calendar year 2016 Members with the diagnosis of Arterial Hypertension in the category of severe	Total number of active members with the diagnosis of Arterial Hypertension in the category of severe who are participants of the DM Program in the measurement period	Number of active members with the diagnosis of Arterial Hypertension in the category of severe as identified in the baseline.
DM5. Major Depression (DEP)	Calendar year 2016 Members with the diagnosis of Major Depression in the category of severe	Total number of active members with the diagnosis of Major Depression in the category of severe who are participants of the DM Program in the measurement period.	Number of active members with the diagnosis of Major Depression in the category of severe as identified in the baseline.

Note: Reference definition for the numerator:

- Participants = Member contacted by the MCO who have a care plan developed.

Goal: To enroll and maintain in DM program at least 22.5% of active severe members by condition at the end of the year. Quarterly reimbursement will be based on achieving at minimum 7.5% of the established goal by quarter.

Note: The MCO will report the amount of members enrolled each quarter. For evaluation purposes, ASES will add any percentage in excess of the goal on the previous quarter to the next quarter (roll over). Minimum goal per quarter must be achieved.

Score: 2 points by condition

B. UM Metrics

Note: ER Visits and Hospital admissions to be included are those related to or a complication of the DM condition being reported.

1. ER Visit Metrics by region and condition for each Physical Health DM

Formula: Number of ER Visits of severe identified DM members annualized / x 1,000
Number of DM members with severe classification

Baseline for FY 2017: Rate of ER visits of members identified as DM candidate from calendar year 2016

Goal by 2017-2018 Q1-Q4: At least 2 % decrease of active severe members ER visits by condition in each quarter.

Score: 2 points by condition

2. Hospital Admission Metrics by region and condition for Physical Health (2 points)

Formula: Number of hospital admissions of severe DM members annualized / x 1,000
Number of hospital admissions of DM members with severe classification

Baseline for FY 2017: Rate of Hospital Admissions of members identified as DM candidate from calendar year 2016

Goal by 2017-2018 Q1-Q4: At least 2% decrease of active severe members hospital admission by condition in each quarter

Score: 2 points by condition

2. For Mental Health DM Metrics are as follows:

A. Percent of participants with Major Depression

Formula: Total number of active members with the diagnosis of Major Depression in the category of severe who are participants of the DM Program in the measurement period / Number of active members with the diagnosis of Major Depression in the category of severe as identified in the baseline.

Baseline for FY 2017: Calendar year 2016 members with diagnosis of Major Depression identified as DM Candidate in the category of severe

Goal by 2017-2018 Q2-Q4: To enroll and maintain in DM program at least 22.5% of active severe members by condition at the end of the year. Quarterly reimbursement will be based on achieving at minimum 7.5% of the established goal by quarter.

Definition reference in this manual are from the Puerto Rico Health Insurance Administration Contract and NCQA (National Committee for Quality Assurance)

Note: The MCO will report the amount of members enrolled each quarter.For evaluation purposes, ASES will add any percentage in excess of the goal on the previous quarter to the next quarter (roll over).

Score: 2 points

B. **UM Metric**

Note: Hospital admissions to be included are those related to or a complication of the DM condition being reported.

1. **Hospital Admission**

Formula: Number of hospital admissions of severe Major Depression in DM annualized / x 1000
Number of hospital admissions of members with severe Major Depression

Goal by 2017-2018 Q1-Q4: At least 2% decrease of hospital admissions of members with severe Major Depression

Score: 2 points

2. Timely and Accurate Hot Spotting Report:

Submit a timely and accurate Hot Spotting Report by region, PMG number, PMG name, PMG population and municipality of residence of members identified as severe in the following conditions:

Physical and Mental Health DM

DM1. Asthma (Bronchial Asthma)
DM2. Diabetes Mellitus (Type 1 or 2)
DM3. Congestive Heart Failure
DM4. Arterial Hypertension
DM5. Major Depression

This report will include for each condition: number of members, percent of the PMGs population, number of active cases and number of interventions.

Score: 1point

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B.PHYSICIAN INCENTIVE PLAN

Physician Incentive Programs are designed to recognize and reward Primary Care Providers who are committed to Preventive Services and improving the quality of the services to all their members. The MCO shall design a Physician Incentive Program that addresses the following key objectives:

- Improve the delivery of care to members for preventive services and chronic conditions
- Align with national quality measures such as those of the Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA).
- Improve patient Care coordination
- Electronic Health Record (EHR)

For purpose of the Quality Incentive Program Retention Fund, ASES will consider the process outcomes described by the MCOs' Incentive Plan and ASES's requirements described below for ***compliance and release to the applicable percent of the retained amount for this particular program***

Process outcome(s) requirements from ASES:

1. Evaluate 100% of the PCPs (with 100 lives as minimum) through Medical Record Review for compliance with clinical and administrative performance measures identified by the Health Plan.
    - The MCO will submit quarterly the reports on the number of PCP eligible by region and those scores obtained on the reported quarter.

   Score: 1 points

2. The MCO shall ensure at a minimum seventy percent (70%) of PCP will be in compliance with eighty percent (80%) scorecard on those indicators approved by ASES and included in the Health Plan Audit during the Contract year.
    - MCO will provide a list by PMG and by region of the certified PCP eligible for the financial incentive that received the preventive services auditing with the percentage of compliance for each PCP evaluated during the reporting period.

   Score: 1 points

Total points for this program 2 points.

Definition reference in this manual are from the Puerto Rico Health Insurance Administration Contract and NCQA (National Committee for Quality Assurance)

VIII. ER QUALITY INITIATIVE PROGRAM

The ER Quality Initiative Program shall be design to identify high users of Emergency Services (including behavioral health) to allow for early interventions of members and physician (PCP) in order to ensure appropriate utilization of services and resources. The program design required by ASES for the ER Quality Initiative will be based on the "Hot Spotting Model of the Camden Coalition of Health Providers". The MCO will submit to ASES for approval a work plan with detailed activities and interventions aimed to High ER Utilizers. The activities and interventions of work plan shall include, but not limited to, the following:

1. Educational campaign to educate consumers about healthcare options available to them when a primary care physician isn't available. The intent of the campaign is to let consumers know the emergency room is not the only alternative when seeking treatment. Options include retail health clinics, walk-in doctor's offices and urgent care centers – all of which, officials say, can provide the same care in less time and less out-of-pocket expense than an ER visit.
2. One on One Care management interventions
3. PCPs interventions on identifying high users or potential high users of ER services.
4. Changes on access to urgent care at PCP offices with extended hours or urgent clinics.

For purpose of the Quality Incentive Program Retention fund, ASES will consider the ER Report and UM Metrics described below for ***compliance and release to the applicable percent of the retained amount for this particular program***.

1. Through a timely and accurate Hot Spotting Report all MCOs will provide ASES the demographic characteristics and PMG information of identified High ER Utilizers by severity level (1 point):

Member identification will be as follows:

Severity Criteria ER Visits	
Level 1: Mild	3-6 visits a year
Level 2: Moderate	7-11 visits a year
Level 3: Severe	12 or more visits a year

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2. Ambulatory Visits Rate (2 points):
   - ***Total Number of Non-Emergency Ambulatory Visits incurred by Active Severe ER Utilizers / Total members on Active Severe ER Utilizers***

     Baseline: Calendar year 2016: Rate of ambulatory visits per severe ER Utilizers

     Goal: 3% quarterly increase in the rate of non-emergency ambulatory visits per severe ER utilizers (Each quarter will be evaluated independently and roll over does not appy to this metric.)
3. Annualized ER Rate on frequent ER users (2 points):
   - ***Total Number of ER Visits incurred by members with 7 or more ER Visits / Total members with 7 or more ER Visits x 1,000***
   - Baseline: Calendar year 2016: Annual rate per thousand of ER visits of members in moderate and severe categories

     Goal: 3% quarterly decrease in number of annualized ER Visits incurred by members with 7 or more ER Visits (Each quarter will be evaluated independently and roll over does not appy to this metric.)

Total points in this program 5 points

Definition reference in this manual are from the Puerto Rico Health Insurance Administration Contract and NCQA (National Committee for Quality Assurance)

IX CONCLUSION

The compliance with the quality categories established in this Manual will be measured and shall be accomplished by the MCO on a quarterly basis. MCO shall comply with the required quarterly metrics in order to receive the reimbursement of the amount retained by ASES for each quarter as defined in Section 23.1 of the Contract.

Definition reference in this manual are from the Puerto Rico Health Insurance Administration Contract and NCQA (National Committee for Quality Assurance)

X APPENDIX A

Disease Management Member Identification and Severity Criteria

Reminder: Events must be related to the DM Condition (based on the diagnosis code)

1. Asthma (Bronchial Asthma) Member Identification Criteria:

Diagnostic Code:	**Medical encounters with any of the following ICD10: J45**
Age	5-56
With at least one of the following events:	
Medications	4 or more asthma medications
ER	At least one visits (CPT: 99281-99285, 99288)
Hospital Admission	At least one hospital admission (CPT: 99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99261-99263, 99291,99292)
Outpatient visits	At least four (4) outpatient encounters (CPT: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 999382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429.)

Severity Criteria:

Severity	**Hospital Admissions**	**ER Visits**	**Outpatient**	**Pharmacy** (Therapeutic categories)
Mild: Comply with all of the following:	0	1	0-3	1
Moderate: Comply with two of the following:	1	2	4-5	2
Severe: Comply with at least one of the following:	≥2	≥3	≥6	≥3 combined categories at least any three months during the baseline year

Exclusions

Patients with emphysema, COPD, Chronic Bronchitis, Cystic Fibrosis and Acute Respiratory Failure

Definition reference in this manual are from the Puerto Rico Health Insurance Administration Contract and NCQA (National Committee for Quality Assurance)

2. Diabetes Mellitus (Type 1 and 2) Member Identification Criteria

Diagnostic Codes	**Medical encounters with any of the following ICD10: E10, E11, E13**
Age	0-75
With at least one of the following events:	
Medications	1 or more
ER Visits	1 or more
Hospital Admission	At least one hospital admission
Outpatient Visits	2 or more

Severity Criteria: At least one of the following

Severity	**Hospital Admissions**	**ER Visits**	**Pharmacy** (Therapeutic categories)	**Complications***
Mild: Comply with all of the following:	0	0	1	0
Moderate: Comply with two of the following:	0	1 ó 2	2	1-2
Severe: Comply with at least two of the following:	≥1	≥3	≥3	≥ 3

*Diabetes related complications including ophthalmic, renal, cardiovascular, skin and neurological.

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3. Congestive Heart Failure Member Identification:

Diagnostic Code	**Medical encounters with any of the following ICD10: I50, I11.0, I13.0, I13.2**
Age	≥18
Medications	*1 or more*
With at least one of the following events:	
ER Visit	1 visit or more
Hospital Admission	1 admission or more
Outpatient Visit	1 or more

Severity Criteria: At least one of the following

Severity	**Hospital Admissions**	**ER Visits**	**Pharmacy (Therapeutic categories)**	**Complications***
Mild: Comply with all of the following:	0	0-1	0-1	0
Moderate: Comply with two of the following:	1	2	2	1-2
Severe: Comply with at least two of the following:	≥ 2	≥ 3	≥3	≥ 3

*CHF related complications including Renal Failure, Heart Valve Disease, Heart Arrhythmia and Liver Disease

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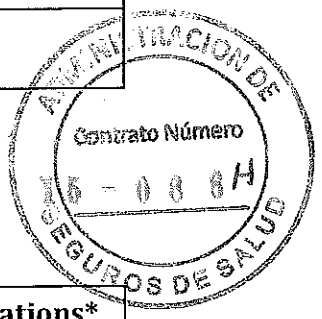
4. Arterial Hypertension Member Identification

Diagnostic Codes	**Medical encounters with any of the following ICD10: I10, I11, I12, I13, I15,**
Age	18+
Medications	1 or more
With at least one of the following events:	
ER Visits	1 or more
Hospital Admissions	1 admission
Outpatient visits	1 or more



Severity Criteria: At least one of the following

Severity	**Hospital Admissions**	**ER Visits**	**Pharmacy (Therapeutic Categories)**	**Complications***
Mild: Comply with all of the following:	0	0-1	0-2	0
Moderate: Comply with two of the following:	1	1 -4	3	1-3
Severe: Comply with at least one of the following:	≥ 2	≥ 5	≥ 4	≥ 4

*Arterial Hypertension related conditions including Myocardial Infarct, Cerebrovascular Accidents, Arterial Aneurism, Renal Disease, Hyperlipidemia and Metabolic Syndrome

Exclusions

Patients with I11.0, I13.0, I13.2

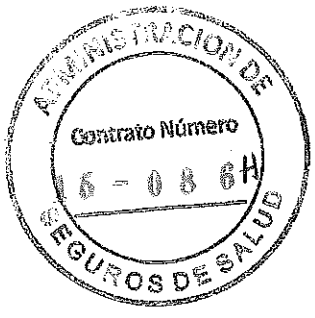
5. Major Depression

Diagnostic Codes	**Medical encounters with any of the following ICD10: F33, F32**
Age	≥ 12
Medications	1 or more
With at least one of the following events:	
ER Visits	1 or more
Hospital Admission	1 or more
Outpatient Visits	1 or more

Severity Criteria: At least one of the following

Severity	**Hospital Admissions**	**ER Visits**	**Pharmacy (Therapeutic Categories)**	**Complications***
Mild: Comply with all of the following:	0	1	1	0
Moderate: Comply with two of the following:	1	2	2	1-2
Severe: Comply with at least one of the following:	≥ 2	≥ 3	≥3	≥ 3

*Complications including chronic pain, chronic physical illness, alcohol or drug abuse, anxiety, panic disorder or social phobias, self-mutilation, suicidal attempts, antisocial disorders



Definition reference in this manual are from the Puerto Rico Health Insurance Administration Contract and NCQA (National Committee for Quality Assurance)