



COMMONWEALTH OF PUERTO RICO

PUERTO RICO MEDICAID
QUALITY STRATEGY

ASES
Asegurando tu Salud
Administración de Seguro de Salud de Puerto Rico



2013-2016

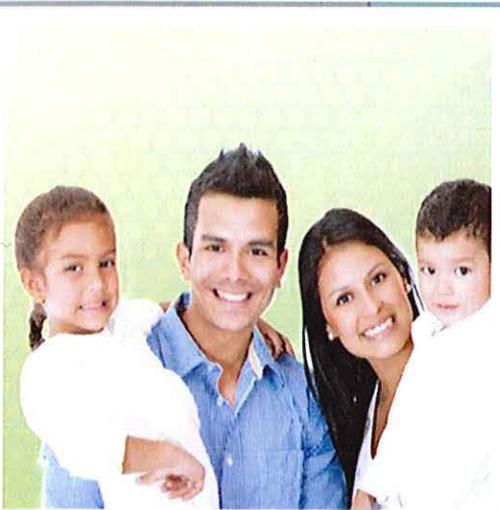




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Section I. Introduction

A. Historical Background

This is the third revision of the Puerto Rico Medicaid Quality Strategy, as required by 42 CFR 438. The Strategy was first developed in 2006 and updated in 2013 and 2014. This document includes the elements of the Quality Strategy required by CMS, but also includes state specific quality goals and measures. As part of a radical reform for the healthcare services in Puerto Rico, the State decided through the Department of Health and its Medicaid Office to delegate the managed care system to the Puerto Rico Health Insurance Administration (PRHIA; known in Spanish with its acronym as ASES meaning the Administración de Seguros de Salud de Puerto Rico).

PRHIA has the responsibility to implement, administer, and negotiate through contractual arrangements those healthcare services included in the Puerto Rico Medicaid State Plan. The contracting of such services will be through those organizations authorized by the federal and State law that will provide risk management as required by the Social Security Act in Title XVIII and XIX, as well under provisions in 42 CFR Part 438 and State Law 72 of September 7, 1993, as amended. These entities are Third Party Administrators (TPA); Prepaid Inpatient Health Plans (PIHP) that will be Managed Behavioral Healthcare Organizations (MBHO); Managed Care Organizations (MCOs); and Medicare Advantage organizations (MAO) that furnish the Medicaid Wraparound Benefit Package for the dually eligible population (Medicare-Medicaid), which are also now as Platino plans. Through these organizations, the State will provide a health insurance system that will furnish access and quality of healthcare of services to all medically indigent eligible population of the island.

The Public Policy of the Commonwealth of Puerto Rico states that the government has an inherent responsibility of furnishing the health care services to the population. Under the terms of this policy, the developments of two health care systems were available with a notorious inequality. Such inequality drove the quality of health care into a correlation and dependability on the financial capability of an individual to address with its own resources the costs of health care. The public policy delineates the duties and responsibilities of the State through its agent, PRHIA, to facilitate and do the following: (1) negotiation, (2) contracting and (3) monitoring by means of a health insurance organization, which includes the quality of healthcare services.

The State has a Quality Task Force composed of representatives from: Department of Health, PRHIA, Providers, and contracted health plan. The State will provide quality by defining those measurements and evaluation mechanisms that will guarantee the assessment, reporting, and measurement of the MI Salud health services at the contracted health plan level in order to establish real improvement at the physician level as well as providing better quality of care to the MI Salud enrollees.

It is important for the State to provide the rules and focus on the performance it want to achieve in order to maximize the resources without limiting access, timeliness, and quality of health care. For that matter, the State 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 MI Salud



enrollees. Through performance improvement projects, performance measures (such as HEDIS, CAHPS, HOS, etc.) as well as monitoring and review those contractual compliance standards provided by the State which will assess the needs and areas of improving the access, timeliness, and quality of health care of our enrollees. In addition, the State has developed a Clinical and Preventive Management Program (i.e., disease management, case management, etc.) that has been modified to increase the health outcomes of the Medicaid population by performing ongoing evaluations to close any breach between the enrollee health care, and the responsibility and role from the healthcare providers.

Since October 1, 2010, the government health program embodies new policy objectives to transform Puerto Rico's health system to promote an integrated approach to physical and behavioral health, and improve access to quality primary and specialty care services. Under this new policy the government health program previously referred to as "Reforma" transformed to "MI Salud". At the present the "MI Salud" programs integrated model continues to provide the appropriate health framework for improving the access of care in a holistic view.

B. Quality Strategy Purpose, Goals, Objectives:

The MI Salud Program is focused on providing quality care to all *Medicaid, Children's Health Insurance Program (CHIP) and Medicare-Medicaid Dual Eligible enrollees* in Puerto Rico through the appropriate and timely access to health care services. The Quality Strategy provides a framework to communicate the State's vision, performance driven objectives and monitoring strategies addressing issues of healthcare services, quality and timely access in Medicaid Managed Care. It is a comprehensive approach that drives quality through initiatives, monitoring, assessment and outcome-based performance improvement.

The specific goals and objectives that play a significant role in the development of the state quality strategy are:

1. Improve timely access to primary and preventive care services for all MI Salud Medicaid, CHIP and Platino dual eligible enrollees.
2. Improve quality of care and services provided to all MI Salud Medicaid, CHIP and Platino dual eligible enrollees through a physical and behavioral health Integrated Model.
3. Improve member's satisfaction with provided services and primary care experience.

Table #1: Puerto Rico Medicaid Strategic Goals and Objectives

1. GOAL: Improve timely access to primary and preventive care services for all MI Salud Medicaid, CHIP and Platino dual eligible enrollees.

Focus Area	Objective	Interventions	Metrics of Assessment
<i>Preventive Care Screening</i> The preventive and screening services identified	Increase the utilization of preventive care and screening services by at least 3% annually,	Provider Incentive Based Program (tied to preventive screenings)	HEDIS reports and Preventive quarterly reports.



<p>for measurably outcomes are:</p> <ul style="list-style-type: none"> * Cancer Screenings (Breast, Cervical) * Asthma Management * Cholesterol Management for High risk population * Diabetes Care Management * HIV test in the first and third trimester of pregnancy woman * Glaucoma screening older adults * Colorectal Cancer screening 	<p>as established in the contractual arrangement between Medicaid, its agent, and the contracted health plan.</p>	<p>Quality Incentive Program as described in section 12.5 of the Mi Salud Contract</p>	
Focus Area	Objective	Interventions	Metrics of Assessment
<p><i>Preventive Care Visits</i> The preventive and screening services identified for measurably outcomes are:</p> <ul style="list-style-type: none"> * Annual Preventive Dental Visits * Preventive care visits * Timeliness in Prenatal Care 	<p>Increase the utilization of preventive care and screening services by at least 3% annually, as established in the contractual arrangement between Medicaid, its agent, and the contracted health plan.</p>	<p>Provider Incentive Based Program (tied to preventive screenings)</p> <p>Quality Incentive Program as described in section 12.5 of the Mi Salud Contract</p>	<p>HEDIS reports and preventive quarterly reports</p>

2. GOAL: Improve quality of care and services provided to all MI Salud Medicaid, CHIP and Platino dual eligible enrollees through a physical and behavioral health Integrated Model.

Focus Area	Objective	Interventions	Metrics of Assessment
<p><i>Behavioral Health Integration Model</i> 1. The behavioral screening services identified for</p>	<p>Increase the number of behavioral health screening services provided to MI Salud enrollees by at least 50%</p>	<p>Provider Incentive Based Program (tied to preventive screenings)</p>	<p>Quarterly reports</p>



Focus Area	Objective	Interventions	Metrics of Assessment
<p>measurably outcomes are:</p> <ul style="list-style-type: none"> * Pregnant women registered by quarter for alcohol and tobacco use with 4P Plus screening tool. * Screening women in post-partum period for depression using Edinburgh screening tool. * Screening of adult members registered in Special Coverage for depression using PHQ-9 screening tool. 		<p>Quality Incentive Program as described in contract section 12.5 of the Mi Salud Contract</p>	

3. GOAL: Improve member’s satisfaction with provided services and primary care experience.

Focus Area	Objective	Interventions	Metrics of Assessment
<p>Consumer Assessment of Healthcare Providers and Systems (CAHPS) The composite item identified for measurably outcomes are:</p> <ul style="list-style-type: none"> * Rating of personal doctor. * Rating of all health care. * Rating of health plan. 	<p>Reach the average score established by AHRQ in the categories of composite items on personal doctor, all health care and health plan</p>	<p>Provider Incentive Based Program as described in contract section 10.7.2 of the Mi Salud Contract</p> <p>Provider Education Program as described in contract section 10.2.2 of the Mi salud Contract</p>	<p>CAHPS annually satisfaction surveys</p>

C. Meeting Goals and Objectives:

PRHIA through its contracts with MCO/ TPA describe what is required in terms of services, deliverables, performance measures and health outcomes. The goals and objectives address and are



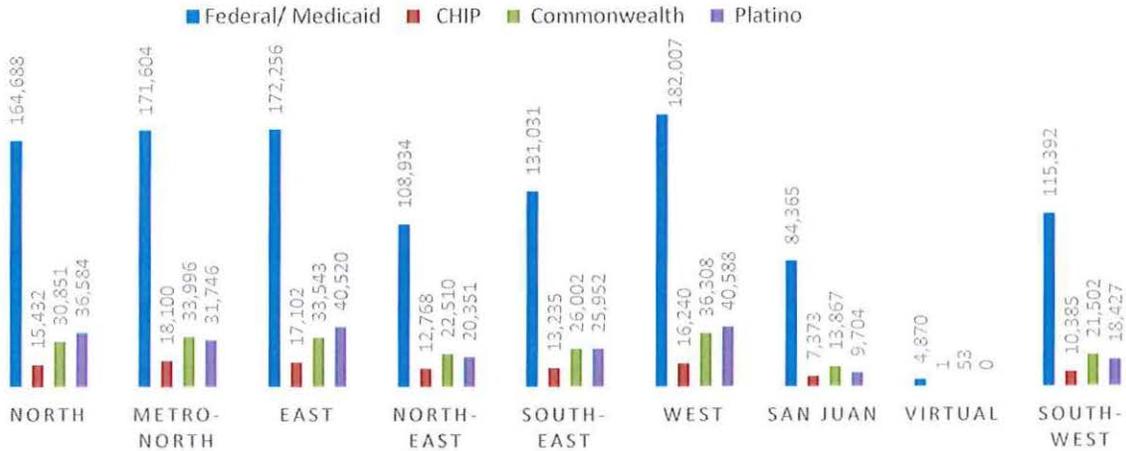
The total population insured under MI Salud, CHIP and Platino dual eligible is of **1,688,287 members** as of April 2014. The following charts and figures illustrates the insured population by service region, eligible category, gender and age.

Table #2: Population by Service region and eligibility category as of April 2014

Region	Federal/ Medicaid	CHIP	Commonwealth	Platino	Total
North	164,688	15,432	30,851	36,584	247,555
Metro-North	171,604	18,100	33,996	31,746	255,446
East	172,256	17,102	33,543	40,520	263,421
North-East	108,934	12,768	22,510	20,351	164,563
South-East	131,031	13,235	26,002	25,952	196,220
West	182,007	16,240	36,308	40,588	275,143
San Juan	84,365	7,373	13,867	9,704	115,309
Virtual	4,870	1	53	-	4,924
South-West	115,392	10,385	21,502	18,427	165,706
Total Medicaid population	1,135,147	110,636	218,632	223,872	1,688,287

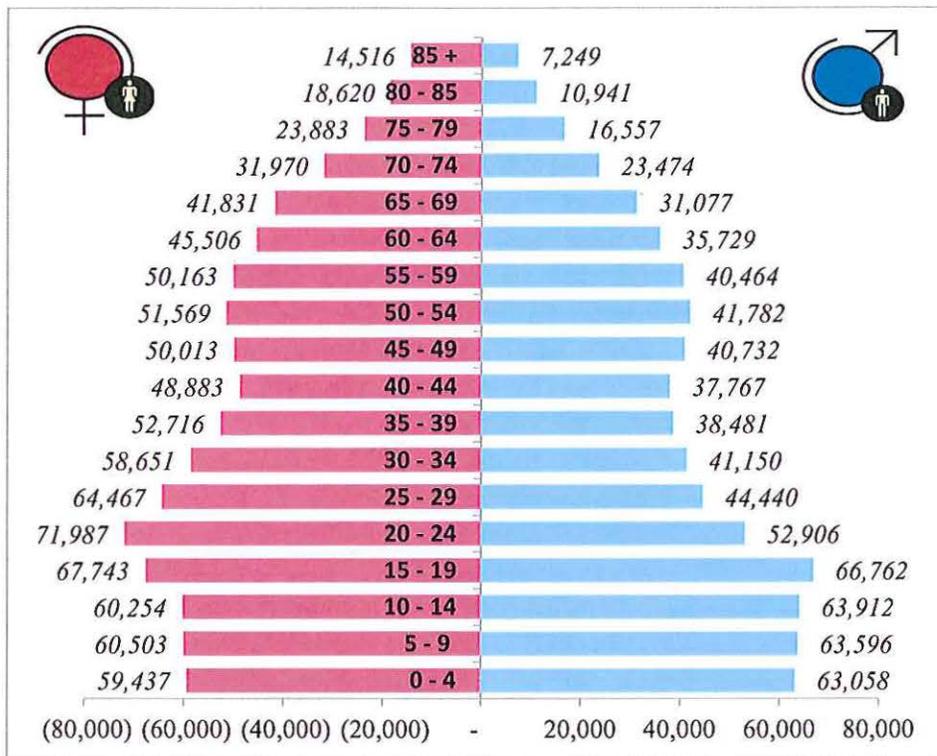


Chart #1: Population by Service region and eligibility category as of April 2014



Source: Medicaid Eligibility Report

Figure #2: Medicaid population by age and gender as of April 2014



Source: Medicaid Eligibility Report



PRHIA through a data driven approach, analyses claims- encounter data and External Quality Review (EQR) report on an annually basis with the purpose to identify and incorporate quality improvement strategies on conditions prevalent in the MI Salud, CHIP and Platino enrollees. The data analysis process provides the opportunity to study strategies and interventions for the prevention of the most prevalent conditions. PRHIA analyzed 2013 claims encounter data files and EQR report for 2012-2013. Data showed that Hypertension, Asthma, Diabetes, End Stage Renal Disease (ERSD), Depression and Attention deficit hyperactivity disorder (ADHD) are the chronic conditions most prevalent in the MI Salud ensured population. The strategies and interventions addressed in this Quality Strategy Plan are focused on the health promotion, prevention and improving the quality of life, care, and services.

E. Quality Strategy Feedback Process:

In accordance with the Federal Regulation CFR 438.202 (b), MI Salud members, Platino members, general public and stakeholders will have the opportunity to provide input and recommendations regarding the content and direction of the Quality Strategy. The Quality Strategy will be posted in PRHIA website and announced in local newspapers. The PRHIA will incorporate recommendations from the MI Salud and Platino members, general public, contracted Health Plans, EQRO and other stakeholders in setting new goals and revising the Quality Strategy.

The PR Medicaid Quality Strategy is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care and quality of service. In accordance with the Federal Regulation CFR 438.202(d) the Puerto Rico Medicaid Office through its agent, PRHIA will perform quarterly reviews of the quality strategy to determine the need for revision and assure that contracted health plans are in contract compliance.

Section II. Assessment

A. Quality and Appropriateness of Care:

The PRHIA assess how well the contracted Health Plans are complying with standards established by the State and consistent with Federal Regulation 42 C.F.R 438. Subpart D, Quality Assessment and Performance Improvement (QAPI) (42 C.F.R. 438.202(c)) through the following mechanisms:

- Contract management
- QAPI (Quality Assessment and Performance Improvement) Program
- State-level data collection and monitoring

All MI Salud contracts include quality provisions. All contracts include requirements for quality measurement, quality improvement, and reporting. PRHIA reviews monthly, quarterly and annual report submissions from the MCO, PIHP and Platino Plans and evaluate whether the managed care entity has satisfactorily met the contract requirements. Another major source of information through which PRHIA assess quality of care is through the requirement of a Quality Assessment and Performance Improvement



Program (QAPI). The QAPI Program is aimed to increase the health outcomes of MI Salud and Platino enrollees through the provision of health services that are consistent, compliance with national guidelines, and NCQA HEDIS standards. The Health plans QAPI Program is submitted to the PRHIA for review and approval.

To evaluate whether MI Salud members are receiving quality care services ,it is imperative to measure and monitor the delivery of these services to improve the quality and care delivery. The PRHIA has developed a performance measure dashboard to monitor and assure quality care to all MI Salud members across multiple preventive services domains. The following measures are collected quarterly:

Table #3: Performance measure dashboard

	Measure	Measure Description :
1	Breast Cancer Screening	The number of women 42-69 years of age who had a mammogram to screen breast cancer.
2	Cervical Cancer Screening	The number of women 24-64 years of age who receive one or more Pap Test to screen for cervical cancer.
3	Cholesterol Management for High Risk Population	Members 18-75 years with a high risk diagnose who have had a LDL-C screening.
4	Diabetes Care Management	Members 18-75 years of age with Diabetes (Type 1 or 2) who had each of the following screening tests: A1c, eye exam, LDL-C, nephropathy screening.
5	Access to Preventive Visits	Members who had at least one preventive care visit with a PCP
6	Annual Dentist Visit	Members 2- 65 who had at least one preventive care visit with a dental provider
7	Timeliness in Prenatal Care	Period when pregnant members initiate prenatal care services
8	Asthma Management	Members who are identified as having persistent Asthma within the current year. Identify the persistent Asthma members by step therapy.



In addition to serving as a performance monitoring and improvement tool, the performance measures dashboard will also serve to promote a standard measurement methodology for the MI Salud program.

B. Special Health Care Needs:

Special health care needs is 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 438.204(b)(1), the PRHIA has established a Special Coverage benefit designed to provide services for Enrollees with special health care needs caused by serious illness.

Health plans 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 PCP, with the Enrollee's participation, and in consultation with any specialists caring for the Enrollee. Health plans require, in its Provider Contracts with PCPs, that Special Registration treatment plans be submitted to the Health plan for review and approval in a timely manner. The Health plans shall coordinate with the MBHO in development of the treatment plan, and shall consider any impact treatment provided by the MBHO may have on the treatment plan. A list of conditions considered in special coverage is included in *Appendix A*.

As part of the MI Salud Integrated Model *Autism* was included as part of the conditions listed in Special Coverage. With this new inclusion, the physical health services that the autism population need to access through specialists as gastroenterologists, neurologists, allergists, and dentists, will be offered through Special Coverage. The MBHO will cover all Behavioral Health Services relating to autism, including collaboration and integration with any treatment plan developed by the contracted health plan. The contracted health plan shall submit a plan for coordination with the MBHO to meet the integration requirement.

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 MCO's at the time of enrollment. In addition the PRHIA requires that all Health Plans have in place a Cultural Competency Plan. This plan must describe how the Providers, individuals and systems within the Contractor's Plan 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 of the individual Enrollees and protects and preserves the dignity of each. Health plans will accept enrollees in accordance with 42 C.F.R. § 434.25 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.

C. State Required Performance Measures:

PRHIA 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 the federal regulation 42 CFR 438.204(c) the PRHIA requires that all Health Plans report, annually the following HEDIS Measures:



Effectiveness of care: Prevention and Screening Measures	MCO/TPA	MBHO	PLATINO
Childhood immunization	√		
Breast cancer screening	√		
Cervical cancer screening	√		
Chlamydia screening	√		
Colorectal cancer screening			√
Glaucoma screening in older adults			√
Care for older adults			√
Osteoporosis management in women who had a fracture			√
Annual monitoring for patients on persistent medications			√
Medication reconciliation post-discharge			√
Potentially harmful drug-disease interactions in the elderly			√
Use of high risk medications in the elderly			√
Board Certification			√
Adult BMI assessment	√		
Weight assessment and counseling for nutrition and physical activities for children and adolescents.	√		
Effectiveness of care: Respiratory Condition Measures:	√		
Use of appropriate medication for people with asthma	√		
Use of spirometer testing in the assessment and diagnosis of COPD			√
Pharmacotherapy management of COPD exacerbation			√
Appropriate treatment for children with upper respiratory conditions	√		



Effectiveness of care: Prevention and Screening Measures	MCO/TPA	MBHO	PLATINO
Effectiveness of care: Cardiovascular Conditions	√		
Cholesterol management for people with cardiovascular conditions	√		
Controlling high blood pressure	√		
Access/ Availability of Care Measures	√		
Comprehensive diabetes care (with all its components)	√		
Adolescent well care visits	√		
Well Child visits in the first 15 months of life	√		
Children and adolescent access to PCP's	√		
Annual dentist visit	√		
Prenatal and postpartum care	√		
Frequency of ongoing prenatal care	√		
Adult access to preventive/ outpatient health	√		
Persistence of Beta-Blocker treatment after heart attack			√
Behavioral Health Measures: Effectiveness of Medical Care and Access			
Antidepressant medication management		√	√
Follow up care for children with prescribed ADHD medication		√	
Follow up after hospitalization for mental and engagement of alcohol and other drug dependence treatment		√	√
Follow up after hospitalization for mental illness (FUH)		√	√
Identification of alcohol and other drug treatment services		√	√



Effectiveness of care: Prevention and Screening Measures	MCO/TPA	MBHO	PLATINO
Mental Health Utilization		√	√

Another state required activity for assessing and monitoring the quality, appropriateness of care and services furnished to MI Salud and Platino enrollees is through Quality Surveys. Health Plans are required to perform Consumer Assessment of Healthcare Providers and Systems (CAHPS) satisfaction survey for Physical health and Experience of Care and Health Outcome (ECHO) for behavioral health (*MI Salud Contract section 12.7*). Both surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. Health Plans shall have a process for notifying providers and Enrollees about the availability of survey findings and making survey findings available upon request. Health Plans 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 (*MI Salud Contract section 12.7.5*).

D. Monitoring and Compliance:

As part of the monitoring and in conformance with 42 CFR 438.206, 438.207, 438.208, 438.210, 438.226, 438.228, 438.230 and 438.240(2) (b) (3), all contracted Health Plans submit to PRHIA utilization statistical reports. The PRHIA requires the following reports, with data to be submitted according to specifications determined in article 18 of the MI Salud contract:

Table # 5: MI Salud Reporting Requirements

MI Salud Contract Article	Frequency and report description
Enrollment (Article 5)	<p>Daily: Report on new Enrollments.</p> <p>Within One Business Day of change: Enrollment Database: notify ASES when Database is updated to reflect a change in the place of residence of an Enrollee.</p> <p>Quarterly: Member Enrollment Materials Report.</p> <p>Biannually: Report on Contractor’s utilization of the Administrative Fee to perform the different administrative services.</p>
Covered Services (Article 7)	<p>Quarterly:</p> <ul style="list-style-type: none"> ▪ Report on EPSDT screening



MI Salud Contract Article	Frequency and report description
	<ul style="list-style-type: none"> ▪ Executive Director’s Report ▪ Executive Director’s Pharmacy Report ▪ Report on the case management services received by Enrollees with specific chronic conditions and associated outcomes. ▪ Report on number of Enrollees diagnosed with predicate conditions for disease management services. ▪ Report on the Maternal and Pre-Natal Wellness Plan.
Provider Network (Article 9)	Monthly: Report on Credentialing and re credentialing status of Providers
Provider Contracting (Article 10)	Quarterly: <ul style="list-style-type: none"> • Reconciliation report of advance payments made to State Health Facilities • Report on Physician Incentive Plan
Utilization Management (Article 11)	Monthly: Health Care Data Reports
Quality Improvement (Article 12)	Quarterly: <ul style="list-style-type: none"> • Network and Out-of Network Providers • Ratio of Enrollees to PCPs • Utilization of Diabetes Disease Management • Utilization of Asthma Disease Management • Utilization of Hypertension Disease Management • EPSDT Utilization • Call Center Report • MI Salud Preventive Services Utilization • Pharmacy Services Utilization • Dental Services Utilization • ER Utilization by Region and by PMG • Prenatal Care Utilization



MI Salud Contract Article	Frequency and report description
	<ul style="list-style-type: none"> • Covered Population by Municipality, Group, Age, and Gender • Medical care and Access measures listed in Section 12.5.3 of this Contract; • Preventive Clinical Programs; • Emergency Room Use Indicators Annual Report: HEDIS Measures in the areas of Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, and Access / Availability of Care.
<p>Fraud, Waste and Abuse (Article 13)</p>	<p>Quarterly:</p> <ul style="list-style-type: none"> • Employee and Contractor Suspension/Disbarment Report • Provider Suspensions and Terminations Report • Fraud, Waste and Abuse Report Within one Business Day of obtaining knowledge: <p>Disclosure of persons debarred, suspended, or excluded from participation in the Medicaid, Medicare or CHIP Programs</p>
<p>Grievance System (Article 14)</p>	<p>Quarterly: Grievance and Appeals Report</p>
<p>Provider Payment Management (Article 16)</p>	<p>Each fifteenth (15th) and (30th) day of each calendar month:</p> <ul style="list-style-type: none"> • Claims Payment Report • Report listing all paid and denied Claims • Pharmacy Claims report • Unclean Claims Report
<p>Information Systems (Article 17)</p>	<p>Monthly: Systems Availability and Performance Report</p> <p>Quarterly:</p>



MI Salud Contract Article	Frequency and report description
	<ul style="list-style-type: none"> • Website Report • Privacy and Security Incident Report
<p>Payment for Services (Article 22)</p>	<p>Monthly:</p> <ul style="list-style-type: none"> • Incurred but not reported (IBNR)report • Administrative Fee Disbursement Report <p>Quarterly:</p> <ul style="list-style-type: none"> • Primary Medical Group (PMG) IBNR Report
<p>Financial Management (Article 23)</p>	<p>Monthly:</p> <ul style="list-style-type: none"> • Report listing Enrollees who have new health insurance coverage, casualty insurance coverage, or a change in health or casualty insurance coverage • Report on Provider stop loss limits <p>Quarterly:</p> <ul style="list-style-type: none"> • Contractor’s findings regarding routine audits of Providers to evaluate cost-avoidance performance. • Contractor’s unaudited quarterly financial statement. <p>Annually:</p> <ul style="list-style-type: none"> • Audited financial statement • Report to the Puerto Rico Insurance Commissioner’s Office • Corporate annual report

E. External Quality Review:

To ensure the accuracy and validity of the data submitted and in compliance with federal regulation 42 CFR 438.204(d), the Puerto Rico Medicaid Program contracts with the External Quality Review Organization (EQRO), Island Peer Review Organization (IPRO). IPRO will conduct annual, external independent reviews of the quality outcomes, timeliness of, and access to, the services covered in this Contract. To facilitate this process the contracted health plans supply data, including but not limited to claims data and



medical records, to IPRO. Upon the request of PRHIA, the contracted health plans provide IPRO its protocols for providing information. To comply with the three mandatory activities as described by Federal regulations, IPRO's scope of work focuses on the following:

1. Performance Improvement Projects (PIP) as required under 42 CFR §438.358 (b) (1); §438.240. The contracted health plans shall conduct performance improvement Projects (PIPs) in accordance with The State and, as applicable, federal protocols. The PIPs defined by the State are a result of encounter-data analysis in support of the results of HEDIS 2013 performance measures activity. The topics of the PIPs are:
 - One (1) in the area of diabetes;
 - One (1) in the area of kidney disease;
 - One (1) in the area of asthma; and
 - One (1) in the area of cardiovascular conditions
2. Quality Performance Measures (HEDIS) as required under 42 CFR §438.358 (b) (2); §438.204 (3) (c). The Contractor shall report, annually, on the following HEDIS measures in the format specified by NCQA (National Committee on Quality Assurance. The HEDIS Measures required by the State are mentioned in State Required Performance measures (page 11).
3. Compliance Evaluation Program (PCEP) as required under 42 CFR §438.358 (b) (3); §438.204 (3) (g); §438.206-242.
4. Incorporation of Medicare Platino data on the following areas:
 - Performance Improvement Projects
 - Performance Measures
 - Health Plan Employer Data Information Systems (HEDIS)
 - Health Outcomes Survey (HOS)
 - Consumer Assessment Health Plan Survey (CAHPS)
 - Chronic Care Improvement Program (CCIP)

In compliance with federal regulation 42 CFR 438.364, IPRO submits to the Puerto Rico Medicaid Program an EQR Technical Report 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 Health plans strengths and weaknesses, as well as recommendations for improvements. PRHIA 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 Puerto Rico Medicaid Quality Strategy.

**Section III. State Standards****A. Access Standards:**

Contract provisions established for contracted Health Plans incorporate specific standards for the elements outlined in 42 CFR §438.206: access to care, structure and operations, and quality measurement and improvement. Health Plans are responsible for communicating established standards to network providers, monitoring provider compliance, and enforcing corrective actions as needed. The PRHIA conducts readiness reviews of the Health Plans operations related to the MI Salud Contract that includes, at a minimum, one (1) on-site review to provide assurances that the Health Plans are able and prepared to perform all Administrative Services. The PRHIA's review documents the status of the Health Plans compliance with the MI Salud Program standards set forth in the contract and this State Quality Strategy. The following table provides the contract provision in each of the mentioned categories:

Access Standards:

Regulatory Reference	DESCRIPTION	MI Salud Contract Reference
§438.206	Availability of Services	9.1.1
§438.206(b)(1)	Maintains and monitors a network of appropriate providers	9.1.2
§438.206(b)(2)	Female enrollees have direct access to a women's health specialist	9.6.1.5
§438.206(b)(3)	Provides for a second opinion from a qualified health care professional	11.6-11.6.3
§438.206(b)(4)	Adequately and timely coverage of services not available in network	9.7
§438.206(b)(5)	Out-of-network providers coordinate with the MCO or PIHP with respect to payment	9.7-9.7.3
§438.206(b)(6)	Credential all providers as required by §438.214	9.1.2
§438.206(c)(1)(i)	Providers meet state standards for timely access to care and services	9.10
§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	9.6.1.6
§438.206(c)(1)(iii)	Services included in the contract are available 24 hours a day, 7 days a week	9.6.1.6
§438.206(c)(1)	Mechanisms/monitoring to ensure compliance by providers	9.10
§438.206(c)(2)	Culturally competent services to all enrollees	6.10
§ 438.207	Assurances of Adequate Capacity and Services	9.22
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment	9.22.2
§438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services	9.22.1.2



Regulatory Reference	DESCRIPTION	MI Salud Contract Reference
§438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution	9.2.1.6
§ 438.208	Coordination and Continuity of Care	9.6.1.1
§438.208(b)(1)	Each enrollee has an ongoing source of primary care appropriate to his or her needs	9.6.1.1
§438.208(b)(2)	All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP	9.6.1.1
§438.208(b)(3)	Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services	9.14
§438.208(b)(4)	Protect enrollee privacy when coordinating care	9.6.1.2
§438.208(c)(1)	State mechanisms to identify persons with special health care needs	9.14.1
§438.208(c)(2)	Mechanisms to assess enrollees with special health care needs by appropriate health care professionals	9.14.1
§438.208(c)(3)	If applicable, treatment plans developed by the enrollee's primary care provider 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	9.14.1
§438.208(c)(4)	Direct access to specialists for enrollees with special health care needs	9.14.2
§ 438.210	Coverage and Authorization of Services	11.3
§438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service	9.1, 11.3.5
§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	10.5.1.3
§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, 11.3.5
§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/PIHP may place appropriate limits on a service, such as medical necessity	7.2.1
§438.210(a)(4)	Specify what constitutes “medically necessary services”	7.2
§438.210(b)(1)	Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	11.1.1



Regulatory Reference	DESCRIPTION	MI Salud Contract Reference
§438.210(b)(2)	Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	11.1.1.1
§438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate health care professional	11.3.5
§438.210(c)	Each MCO/PIHP 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	14.4.4.1
§438.210(d)	Provide for the authorization decisions and notices as set forth in §438.210(d)	11.1.1.3
§438.210(e)	Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services	16.1.11/9.13

B. Structure and Operations Standards:

PRHIA has contractual requirements in place for ensuring Health Plans compliance with the structure and operational standards of 42 CFR 438.214. In the event of a change in the contract or contracted Health Plans, the PRHIA will revise and incorporate any changes needed to the State Quality Strategy. PRHIA will report these revisions to CMS for review and approval. The following table provides the contract provisions under the MI Salud contract in each of the mentioned categories:

Regulatory Reference	DESCRIPTION	MI Salud Contract Reference
§438.214	Provider Selection	9.4.8
§438.214(a)	Written policies and procedures for selection and retention of providers	4.9.1.5
§438.214(b)(1)	Uniform credentialing and re-credentialing policy that each MCO/PIHP must follow	9.4.2
§438.214(b)(2)	Documented process for credentialing and re-credentialing that each MCO/PIHP must follow	9.4.3-9.4.3.15
§438.214(c)	Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment	10.1.7
438.214(d)	MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs	9.17
§438.218	Enrollee Information	4.9.1.6
§438.218	Incorporate the requirements of §438.10	4.9.1.6



Regulatory Reference	DESCRIPTION	MI Salud Contract Reference
§438.224	Confidentiality	34
§438.224	Individually identifiable health information is disclosed in accordance with Federal privacy requirements	34.1
§438.226	Enrollment and Disenrollment	4.4-4.5
§438.226	Each MCO/PIHP complies with the enrollment and disenrollment requirements and limitations in §438.56	4.9.1.8
§438.228	Grievance Systems	14.1
§438.228(a)	Grievance system meets the requirements of Part 438, subpart F	14.1.3
§438.228(b)	If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner	14.1.4
§438.230	Sub-contractual Relationships and Delegation	30.1
§438.230(a)	Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	30.1.1
§438.230(b)(1)	Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	30.1.3
§438.230(b)(2)	Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate	30.1.2
§438.230(b)(3)	Monitoring of subcontractor performance on an ongoing basis	30.1.3
§438.230(b)(4)	Corrective action for identified deficiencies or areas for improvement	30.1.3

C. Measurement and Improvement Standards:

MI Salud contracts require an ongoing program for quality assessment and performance improvement of the services provided to enrollees as required in federal regulation 42 CFR §438.236 – §438.242. Quality measurement and improvement standards include clinical practice guidelines, Preventive Clinical Programs, Behavioral and Physical Health Integration, and Health Information Systems. Each of these standards is defined as follows:

1. Clinical Practice Guidelines:

The PRHIA requires that Health plans 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 US Task Force on Preventive Care, American Medical Association's Guidelines for Adolescent and Preventive Services, Substance Abuse and Mental Health Services Administration (SAMHSA), American Psychological Association (APA),



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

2. Preventive Clinical Programs:

As part of the required improvement programs, the State has established Clinical standards/guidelines for which each contracted health plan is required to develop a Preventive Clinical Program. This allows for better utilization management mechanisms and guaranteeing access to healthcare in a timely manner for the prevention of diseases and promoting health among the MI Salud population. This program includes, but is not limited to:

- A. Disease Management for Physical and Mental Health:** The Disease Management Program focuses on those conditions: Diabetes, Asthma, Hypertension, Congestive Heart Failure and other cardiovascular disease, Depression and Diabetes Type 2, Obesity and Chronic renal disease, level 1 and 2. The program has severity level criteria for identification of enrollees with these conditions. The contracted health plans primarily focus is to reach the severe cases for utilization, preventability and cost-effectiveness purposes. The interventions carried out by the contracted Health plans are based on health education and prevention activities at secondary preventive level.
- B. Case Management Program:** This program is driven towards the management of high-risk cases, which the contracted health plan has decided to uphold under their risk without limiting the Primary Care Physician (PCP) role as part of the Medicaid Managed Care System.
- C. Prenatal Care Program:** This program focus on providing access to prenatal care services during the first trimester and 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 toward the promotion of healthy lifestyles and adequate pregnancy outcomes through Educational workshops regarding prenatal care topics (importance of Pre-natal medical visits and post-partum care), breast-feeding, stages of childbirth, oral and mental health, family planning, and newborn care, among others. In addition, the program engages in the proper access and provision of those screening test during the pregnancy.
- D. Provider Education Program:** The purpose of this program is to provide an ongoing educational activity on clinical and non-clinical topics as well as considering any issue derived from the MI Salud population needs. The State Medicaid Agency through its Agent requires the contracted health plan that each PCP must comply with 20 contact hours on an annual basis, or five contact hours on a quarterly basis. Delivery of the Provider Education curriculum and schedule to the State Medicaid agent (PRHIA) is necessary for approval prior to execution and implementation of such.

3. Integration of Physical and Behavioral Health Services:

The State has established the "integration model" to ensure that physical and behavioral health services are closely interconnected, ensure optimal detection, prevention, and treatment of physical



and mental illness. The integration model focuses on ensuring that both physical and mental health providers develop a Coordination and Continuity of Care plan (42 CFR 438.208) with case managers as the gateways between the enrollees and the primary care and mental health providers.

4. Health Information Systems:

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

- Consolidates all data information from all payers.
- Monitor profitability at contracted health plan level.
- Monitors prompt payment to providers.
- Measures and benchmark contracted health plan performance.
- Audit claim overpayments.
- Accurately displays and monitors cost trends.
- Identifies and tracks diseases, disease treatment patterns, and costs of diseases.
- Support medical and epidemiological studies.
- Builds projected budgets.
- Models program and benefit changes. In compliance with federal regulation 438.242, the

PRHIA require that all Health plans must maintain system hardware, software, and information systems (IS) 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 MI Salud programs, including, but not limited to, data pertaining to providers, Members, Claims, Encounters, Grievance and Appeals, disenrollment HEDIS and other quality measures. Health plans information systems must comply with the most current federal standards for encryption of any data that is transmitted via the internet by the Health plans or its subcontractors and transmit electronic Encounter Data to PRHIA according to Encounter Data submission standards.

A. Medicaid Management Information System (MMIS): The State has initiated a project to improve the health of individuals, families and communities in Puerto Rico 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 MI Salud program.



- Leverage MMIS to achieve common outcomes for HIT and Health Reform initiatives.
- Develop infrastructure capacity, and establish business processes within the Medicaid Enterprise, to provide adequate oversight of the MI Salud program.
- Increase credibility with “MI Salud” stakeholders and CMS.

B. Health Information Technology Provider Incentive Program (HITPIP): HITPIP is a Medicaid Program created to incentive certain individuals and hospitals to acquire a certified Electronic Healthcare Record system according to 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- Pres. Obama. The HITPIP has two stages:

- Adopt, Implement or Upgrade
- Meaningful Use

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

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

Section IV. Improvement and Interventions

The PRHIA will utilize a variety of State initiative to improve the quality of care delivered by the Health plans for MI Salud and Platino enrollees. Some of these improvement interventions are:

1. **Super Utilizers Project:** The PRHIA has been awarded a technical assistance grant from the National Governors Association with the main goal of identifying members with high utilization and poor health outcomes. The program’s main goal is to educate members and try to eliminate social and behavioral health barriers to care. Other program goals are to improve overall physical and mental health and healthcare quality outcomes in underserved communities in Puerto Rico while reducing overall health care costs. One of the main strategies of the project is to coordinate care using a strong interdisciplinary care team approach that is supported through coordinated efforts with the members’ primary care physicians (PCPs). Members will be identify by claims data, following the criteria’s 4 or more ER Visits + 2 or more Inpatient admissions, use of multiple drugs and social/behavioral barriers to care. The Super Utilizers program was launched January 1, 2014. The program will be monitored on a monthly basis and quality impact will be



evaluated six months after the first year of performance to allow for enough data to be collected for proper evaluation.

The Super Utilizer program has three main areas; a) assessment phase, b) main intervention phase and c) graduation phase. Each phase is described in the following table:

<i>Super Utilizer program phase</i>	<i>Description</i>
Assessment Phase (1-3 months)	<ul style="list-style-type: none"> • Contact members • Conduct Assessments • Root Cause Analysis of 4 Triggers • Establish Care Plan
Main Intervention Phase (6-10 months)	<p>Execute Care Plan by Conducting Interventions:</p> <ul style="list-style-type: none"> • Educational Interventions for Members and PCPs • Clinical Interventions • Care Coordination • Care Transitions • Nutritional Services • Social Interventions • Psychological Interventions • Community based Interventions • Outreach to members for motivation • Encourage members to take responsibility for their health. • Foster compliance and adherence with treatment.
Graduation Phase (1-3 months)	Member and PCP complete integration and can manage the patient's health independent from the program.

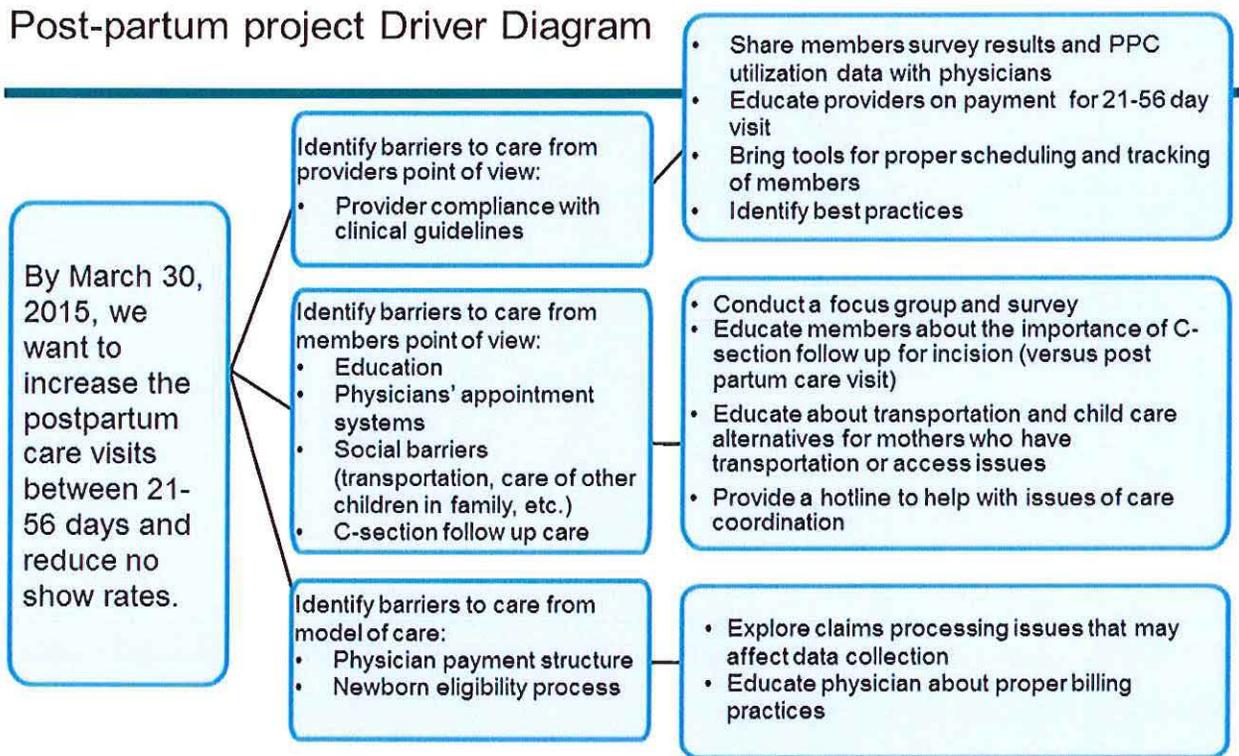
2. **Post -Partum Care Quality Initiative:** PRHIA has been selected to participate in a QI 201 Action Learning Series sponsored by CMS. The action learning series is a team-based collaborative learning experience. Over the next nine months, PRHIA will be building the improvement team, and work with members of the Technical Assistance/Analytic Support Program team and staff at the Center for Medicaid and CHIP Services (CMCS) on the Postpartum Care quality improvement (QI) project.

- a. **Aim:** By March 30, 2015, we want to increase the postpartum care (PPC) visits between 21 and 56 days and reduce no-show rates.
- b. **Approach:**By working with the 4 medical practices in the Metro-North region with the highest volume of births, we will increase the PPC Visits within the 21-56 day period by 50% in the Metro North (MN) Region.



- c. Measurement and Data Collection Strategy for the Post-partum care initiative:
 - i. Increase of at least 50% in PPC visits within the metro-north region. Measurement period: May 1, 2014 through April 30, 2015. Final reporting date (Close of project) August 31, 2015 (Baseline Data Year 2013)
 - ii. Measurements are going to be performed on a monthly basis by claims data analysis and physician-reported data via the Quality Department.
- An expected level of PPC visits was established based on 2013 utilization experience. Achievements will be measured based on cumulative utilization experience.

Figure #3: Post-partum driver diagram:



- 3. **Provider Incentive Based Program:** This program objective is to provide incentives on cash or risk basis towards the physician performance providing preventive services according to EPSDT for 0 to 21 years old population as well as other screening tests for the 21 and older population. The program will include the following elements to provide the incentive:
 - Compliance with the attendance to the Provider Education Program.
 - Compliance with the provision of preventive services.
 - Compliance with appropriate management of patients with chronic conditions (asthma, diabetes, hypertension, congestive cardiac failure, chronic kidney disease and obesity);



- Compliance with the provision of medical and dental services in Head Start Programs (the Contractor shall require Providers to complete a physical exam sheet for Head Start Programs at no cost to the Enrollee);
- A diminution in Complaints, Grievances, and Appeals as a percentage of all Encounters; and Management of medical records.

Section V. Patient Safety

In accordance with Section 2702 of the PPACA, Health Plans must have mechanisms in place to prevent payment for the following Provider preventable conditions:

- All hospital acquired conditions as identified by Medicare other than deep vein thrombosis (DVT)/Pulmonary Embolism (PE) 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.

Patient Safety Initiative:

The PRHIA and University of Puerto Rico, Medical Sciences Campus, and School of Pharmacy has joined into a collaborative agreement to initiate an Influenza Vaccine Research Initiative addressing Patient Safety topic. Through claims and encounter data analysis the study will address the impact and effectiveness of the Influenza Vaccination to the elderly people >65. Puerto Rico has a high prevalence of Influenza Virus and other studies demonstrated the vaccine reduce risk. The major objective of the research is to investigate the correlation between emergency room's visit and hospitalization of people who has vaccinated. The expected initiation project is on July 2014.

Section VI. Intermediate Sanctions:

In the event the Health plans are in default as to any applicable term, condition, or requirement of the MI Salud Contract, and in accordance with any applicable provision of 42 CFR 438.700 and Section 4707 of the Balanced Budget Act of 1997, at any time on or after one hundred twenty (120) Calendar Days following the Effective Date, the Contractor agrees that, in addition to the terms of Section 35.1.1 of the MI Salud Contract, the PRHIA may impose intermediate sanctions against the Health Plan for any such default in accordance Article 19 of the MI Salud Contract

Section VII. Conclusions and Opportunities:

Rates of the HEDIS measures continue to be lower than national benchmarks for a large percentage of the measures. The PRHIA will focus improvement on the conditions of Hypertension, Diabetes, End Stage Renal Disease, ADHD and smoking cessation, providing the opportunity to study strategies for the



prevention of these chronic diseases. Lessons learned from the PIPs will continue to be incorporated into the State's Quality Strategy. In addition, the PRHIA will also continue to work on improving behavioral health outcomes and access to care.



Appendix A: Special Health Care Needs Coverage

Benefits provided under the special coverage are subject to pre-authorization by the contracted Health plan. Beneficiaries will have the right to freely choose the providers of these services, among those in the insurer's network, pending final coordination with said provider. Differential diagnostic interventions, up to final diagnostics verification are not part of the special coverage.

Medications, laboratories, diagnostic tests, and other related procedures specified in this coverage that are necessary for the ambulatory treatment or convalescence care are part of this coverage and do not require pre-authorization of the primary care physician or the Health Plans. The Health Plan must identify the patients included in this coverage for easy access to the contracted services.

The purpose of this coverage is to facilitate the effective management of beneficiaries with special health condition that require specialized medical attention. This Coverage will become effective when the diagnosis is confirmed through the results of tests or procedures performed. The benefits under this coverage are:

- Coronary disease services and intensive care, without limitations
- Maxillary surgery.
- Neurosurgical and cardiovascular procedures, including pacemakers, valves and any other instrument or artificial device (Requires preauthorization)
- Clinical and pathological laboratory test that must be sent outside Puerto Rico for their processing (Requires preauthorization)
- Neonatal intensive care unit services, without limitations
- Treatment with radioisotopes, chemotherapy, radiotherapy and cobalt.
- Gastrointestinal conditions, allergies and nutritional evaluation for autistic patients.
- The following procedures and diagnostic tests, when medically necessary (Require preauthorization):
 - ✓ Computerized Tomography
 - ✓ Magnetic resonance tests
 - ✓ Cardiac Catheterisms
 - ✓ Holter Test
 - ✓ Doppler Test
 - ✓ Stress Test
 - ✓ Lithotripsy
 - ✓ Electromyography
 - ✓ Tomography test (SPECT)
 - ✓ Ocular Pletismography test (OPG)
 - ✓ Impedance Pletismography (IPG)
 - ✓ Other neurological cerebral-vascular and cardiovascular tests, invasive or non-invasive
 - ✓ Nuclear Medicine tests
 - ✓ Diagnostic Endoscopies



✓ Genetic Studies

- Physical therapy – up to 15 additional treatments per condition per beneficiary a year, when ordered by an Orthopedist or Physiatrist (Require preauthorization from your plan)
- General Anesthesia.
 - ✓ General anesthesia for dental treatment to children with special needs.
- Hyperbaric chamber.
- Immunosuppressive drugs and laboratory tests required for the maintenance treatment of patients who have been operated to receive any transplant, which assure the stability of the beneficiary's health and the emergencies that may arise after this surgery.

Treatment for the following conditions after being confirmed by the results of laboratory tests and the diagnosis has been established:

- Aplastic Anemia:
- Rheumatoid Arthritis
- Autism
- Cancer
- Chronic Kidney Disease Stages 3- 5: The following is a description of the stages of chronic renal disease:
 - ✓ **Level 3** - FG (glomerular filtration - ml / min. bu 1.73 m² per unit of body area) between 30 and 59, a moderate decrease in kidney function
 - ✓ **Level 4** - TFG between 15 and 29, a serious decrease in kidney function
 - ✓ **Level 5** - TFG under 15, renal failure with probability of dialysis or kidney transplantation.
- Scleroderma
- Multiple Sclerosis and Amyotrophic lateral sclerosis
- Cystic Fibrosis
- Hemophilia
- Leprosy
- Systemic Lupus Erythematosus
- Children with special health needs
- Obstetrics
- Tuberculosis
- HIV/AIDS