



COMMONWEALTH OF PUERTO RICO

PUERTO RICO MEDICAID
QUALITY STRATEGY

2013-2016

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Section I. Introduction

Historical Background

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 (MCO) and Medicare Advantage organizations (MAO) that furnish the Medicaid Wraparound Benefit Package for the dually eligible population (Medicare-Medicaid). 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) negotiating, (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 Provider 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 wants 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. Performance improvement projects, performance measures (such as HEDIS, CAHPS, HOS, etc.) as well as monitoring and review of contractual compliance standards provided by the State are the key elements the Puerto Rico Medicaid Program uses for the proper assessment and identification of improvement in 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.

Effective October 1, 2010, the Government Health Program embodied new policy objectives to transform Puerto Rico's health system in order 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 in to "MI Salud".

Quality Strategy Purpose, Goals, Objectives:

The MI Salud Program is focused on providing quality care to all *Medicaid and Dual Eligible enrollees* in Puerto Rico through the appropriate and timely access to health care services. The Quality Strategy Plan 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:

Goals:

1. Improve timely access to primary and preventive care services for all MI Salud Medicaid and Platino dual eligible enrollees.
2. Improve quality of care and services provided to all MI Salud and Platino dual eligible enrollees through a physical and behavioral health Integrated Model.

Objectives:

<i>Focus Area</i>	<i>Objective</i>	<i>Target</i>
<i>Preventive Screening</i>	Demonstrate an increase in 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.	The preventive and screening services identified for measurably outcomes are: <ul style="list-style-type: none"> * Cancer Screenings (Breast, Cervical) * Asthma Management * Preventive care visits * Annual Preventive Dental Visits * Timeliness in Prenatal Care * Cholesterol Management for High risk population * Hgac1 Screening for all enrollees with Diabetes * Depression screening * Postpartum depression screening * Alcohol and Tobacco use screening for pregnant



<p><i>Behavioral Health Integration Model</i></p> <p><i>Provider Network</i></p>	<p>Continue to review the Integration Model of physical health care with behavioral health care through a Collocation model approach which provides <i>healthcare</i> services in a unified primary care setting in order to develop meaningful objectives</p> <p>Demonstrate improvement in access to available primary care services by having the plan meet the Provider Network ratios:</p>	<p>enrollees.</p> <p>Number of Primary Medical Groups Active in Collocation Model</p> <ul style="list-style-type: none"> * One Primary Care Physician per 1,700 Enrollees (1:1,700). (2)1:2,800 will apply to gynecologist/obstetricians selected as the female enrollee Primary Care Physician * One specialty of the ones mentioned below for each 2,200 Enrollees (1: 2,200): Cardiologists, Gastroenterologists, Pneumologists, Endocrinologists and Urologists. * One Primary Behavioral Health Provider per 5,000 Enrollees (1: 5,000); * One provider duly trained and certified by the Substance Abuse and Mental Health Administration (SAMHSA) for the treatment of opiates.
<p><i>Disease Management</i></p>	<p>Demonstrate increase in MI Salud enrollee’s access to self-manage chronic conditions through participation of clinical and educational monthly interventions.</p>	<p>Diabetes Asthma Hypertension Congestive Heart Failure Depression and Diabetes Type 2 Obesity Chronic renal disease, level 1 and 2.</p>
<p><i>Utilization Management</i></p>	<p>Develop a Utilization Management Reporting Protocol for MA Platino Plans in order to develop objectives for improvement in preventive care services.</p>	<p>Utilization Management Reporting Protocol for Platino Plans by December 2014.</p>



Meeting Goals and Objectives:

- The methods employed by PRHIA to achieve these goals and objectives include the following strategies:
- Developing and maintaining collaborative strategies among State agencies and stakeholders to improve health education and health outcomes, manage vulnerable and at-risk members.
- Using additional performance improvement projects and emerging practice activities to drive improvement in member health care outcomes.
- Strengthening prevention, wellness, and health management initiatives to improve Mi Salud and Platino members’ health status.
- Improving health information technology to ensure that information retrieval and reporting are timely, accurate, and complete.

Membership Update:

The Commonwealth has sole authority to determine eligibility for MI Salud, as provided in federal law and Puerto Rico’s State Plan, with respect to the Medicaid and CHIP eligibility groups. For the delivery of services under MI Salud, ASES has divided Puerto Rico into nine regions: eight geographical service regions and one "Virtual Region." The "Virtual Region" encompasses services provided throughout Puerto Rico to two groups of Enrollees: children who are under the custody of Administration of Family and Children (Administración de Familia y Niños “ADFAN”) and certain survivors of domestic violence referred by the Office of the Women’s Advocate, who enroll in the MI Salud program. The following map illustrates the eight geographical service regions as of October 2013.

**Puerto Rico Health Insurance Administration
Service Region Distribution**



The total population insured under Mi Salud and Platino dual eligibles is of 1,674,292 members as of October 2013. The following table illustrates the insured population by service region and eligible category.



<i>Region</i>	<i>Federal/Medicaid</i>	<i>SChips</i>	<i>Commonwealth</i>	<i>Platino *</i>	<i>TOTAL</i>
North	157,133	17,418	35,724	35,049	245,324
Metro-north	162,116	21,149	40,331	31,801	255,397
East	160,876	20,015	39,501	38,877	259,269
North-east	102,208	14,360	26,111	20,336	163,015
South-east	123,212	15,036	30,042	25,084	193,374
West	170,246	19,055	43,387	39,043	271,731
San Juan	82,433	8,344	15,966	9,912	116,655
Virtual	4,976	-	55	-	5,031
South-west	109,187	12,070	25,536	17,703	164,496
Medicaid population distribution	1,072,387	127,447	256,653	217,805	1,674,292

*Platino = dual eligible

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 a public notice will inform in local newspapers the availability, upon request, of the Quality Strategy at PRHIA offices. . 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

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 (42 C.F.R. 438.202(c)) by the collection and analyses of data from many sources. One of the major sources of information is through the requirement of a Quality Assessment and Performance Improvement Program (QAPI). The QAPI Program is aimed at increasing 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 Heath Plans QAPI Program is submitted to the PRHIA for review and approval.

**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 1*.

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 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.

State Required 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:

1. Physical Health Measures:**Effectiveness of Care: Prevention and Screening Measures:**

- Childhood immunization;
- Breast cancer screening;
- Cervical cancer screening;
- Chlamydia screening;
- Adult BMI assessment; and



- 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.
- Appropriate treatment for children with upper respiratory conditions.
- 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 PCPs;
- Annual dentist visit;
- Prenatal and postpartum care;
- Frequency of ongoing prenatal care;
- Adult Access to preventive/outpatient health

2. 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 illness and engagement of alcohol and other drug dependence treatment;
- Identification of alcohol and other drug treatment services
- Mental Health Utilization.

Another key activity for assessing and monitoring the quality and appropriateness of care and services furnished to Mi Salud and Platino enrollees is through Quality Surveys. Health Plans are required to perform two (2) satisfaction surveys (*Mi Salud Contract section 12.7*). One satisfaction survey is directed to enrollees and the other survey directed to Providers. 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 Provider and Enrollee surveys for monitoring service delivery and quality of services and for making program enhancements (*Mi Salud Contract section 12.7.5*).

Monitoring and Compliance:

As part of the monitoring and in conformance with 42 CFR 438.240(2)(b)(3), all contracted Health Plans shall submit to PRHIA, on a quarterly basis, 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:



<i>Contract Article</i>	<i>Frequency</i>	<i>General Description of requirement</i>
Contractor Responsibilities – Enrollment (Article 5)	Daily	Report on new Enrollments
	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
	Quarterly	Member Enrollment Materials Report
Covered Services (Article 7)	Bi-Annually	Report on Contractor’s utilization of the Administrative Fee to perform the different administrative services.
	Quarterly	Report on EPSDT screening
	Quarterly	Executive Director’s Report
	Quarterly	Executive Director’s Pharmacy Report
	Quarterly	Report on the case management services received by Enrollees with specific chronic conditions and associated outcomes
	Quarterly	Report on number of Enrollees diagnosed with predicate conditions for disease management services
	Quarterly	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	Reconciliation report of advance payments made to State Health Facilities
	Quarterly	Report on Physician Incentive Plan
Utilization Management (Article 11) Quality Improvement (Article 12)	Monthly	Health Care Data Reports
	Quarterly	Reports on: 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



<i>Contract Article</i>	<i>Frequency</i>	<i>General Description of requirement</i>
Quality Improvement (Article 12)	Quarterly	<p>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 Covered Population by Municipality, Group, Age, and Gender Various HEDIS medical care and Access measures listed in Section 12.5.3 of this Contract; Preventive Clinical Programs; Emergency Room Use Indicators</p>
	Annually	<p>Report on 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)	Quarterly	<p>Employee and Contractor Suspension/Disbarment Report</p> <p>Provider Suspensions and Terminations Report</p> <p>Fraud, Waste and Abuse Report</p>
	Within one Business Day of obtaining knowledge Quarterly	<p>Disclosure of persons debarred, suspended, or excluded from participation in the Medicaid, Medicare or CHIP Programs Grievance and Appeals Report</p>
Grievance System (Article 14) Provider Payment Management (Article 16)	Each fifteenth (15th) and (30th) day of each calendar month	<p>Claims Payment Report</p>
	Each fifteenth (15th) and (30th) day of each calendar month	<p>Report listing all paid and denied Claims</p>
	Monthly	<p>Encounter Data</p>



<i>Contract Article</i>	<i>Frequency</i>	<i>General Description of requirement</i>
Information Systems (Article 17)	Quarterly	Findings and corrective measures taken with respect to encounter registration and reporting
	Each fifteenth (15th) and (30th) day of each calendar month	Pharmacy Claims report
	Each fifteenth (15th) and (30th) day of each calendar month	Unclean Claims Report
	Monthly	Systems Availability and Performance Report
Payment for Services (Article 22)	Quarterly	Website Report
	Quarterly	Privacy and Security Incident Report
	Quarterly	Actuarial Report
Financial Management (Article 23)	Monthly	IBNR report
	Monthly	Administrative Fee Disbursement Report
	Quarterly	PMG IBNR report
	Quarterly	Contractor’s findings regarding routine audits of Providers to evaluate cost-avoidance performance
	Quarterly	Contractor’s unaudited quarterly financial statement
	Monthly	Report listing Enrollees who have new health insurance coverage, casualty insurance coverage, or a change in health or casualty insurance coverage
	Monthly	Report on Provider stop loss limits
	Annually	Audited financial statement
Annually	Report to the Puerto Rico Insurance	



<i>Contract Article</i>	<i>Frequency</i>	<i>General Description of requirement</i>
	Annually	Commissioner's Office Corporate annual report
	Annually	Report on Controls Placed in Operation and Tests of Operating Effectiveness
	Annually	Disclosure of Information on Annual Business Transactions

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 the Contracts with the Health Plans. 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 as follow:
 - 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).
- 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 will submit 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

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 tables provide the contract provision in each of the mentioned categories:

Access Standards:

<i>Regulatory Reference</i>	<i>DESCRIPTION</i>	<i>MI Salud Contract Reference</i>
§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,	9.6.1.6



<i>Regulatory Reference</i>	<i>DESCRIPTION</i>	<i>MI Salud Contract Reference</i>
	7 days a week	
§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
§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
§438.210(b)(2)	Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	11.1.1.1



<i>Regulatory Reference</i>	<i>DESCRIPTION</i>	<i>MI Salud Contract Reference</i>
§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

Structure and Operations Standards:

<i>Regulatory Reference</i>	<i>DESCRIPTION</i>	<i>MI Salud Contract Reference</i>
§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 recredentialing policy that each MCO/PIHP must follow	9.4.2
§438.214(b)(2)	Documented process for credentialing and recredentialing 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
§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



<i>Regulatory Reference</i>	<i>DESCRIPTION</i>	<i>MI Salud Contract Reference</i>
§438.230	Subcontractual 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

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, performance improvement programs, and health information systems. Each of these standards is defined as follows:

1. Clinical Standards/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, SAMHSA, 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 these conditions: Diabetes, Asthma, Hypertension, Congestive Heart Failure and other cardiovascular diseases, 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 screening tests 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 Office 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. Performance Improvement Programs:**
The PRHIA has defined the following PIP's for Mi Salud Contract:
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
One (1) in the area of Diabetes and Depression
One (1) in the area of Obesity and Depression
One (1) in the area of autism
One (1) in the area of ADHD
- 4. 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.
- 5. Health Information Systems:** The PRHIA Information Systems has under gone transformation for an Underwriting and Actuarial Database Implementation. The MedInsight project was



designed to transform data into knowledge, using Milliman's proprietary relational database tools to perform analysis and reporting with the capability to extract and provide multidimensional views of the data. The Med Insight system offers a suite of products designed to work together to provide a complete data reporting and analysis solution. With Med Insight, PRHIA can perform the following functions:

- Consolidate all data information from all payers.
- Monitor profitability at contracted health plan level.
- Monitor prompt payment to providers.
- Measure and benchmark contracted health plan performance.
- Audit claim overpayments.
- Accurately displays and monitors cost trends.
- Identify and tracks diseases, disease treatment patterns, and costs of diseases.
- Support medical and epidemiological studies.
- Build projected budgets.
- Model 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: (1) accept, transmit, maintain and store electronic data and enrollment files; (2) 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.

Section IV. Improvement and Interventions

The PRHIA will utilize a variety of interventions 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 identified by claims data, following the criteria of 4 or more ER visits plus 2 or more inpatient admissions, and use of multiple drugs and social/behavioral barriers to care. The Super Utilizers program is scheduled to begin 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 and mature data to be collected for proper evaluation.

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. By April 2014, improvement teams of the selected states will share results that reflect improvement in their selected maternal and infant health area of focus.
3. **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.
4. **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



5. 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.

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 execution 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 with the pertinent sections of the MI Salud Contract.

Section V. 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.